ALASKA HOSPITAL AND HEALTHCARE ASSOCIATION

Child and Adolescent Behavioral Healthcare Improvement Project

Report and Recommendations for Positive Change Across the Continuum

December 2022

Trust
Alaska Mental Health Trust Authority

ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

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Executive Summary

Project Purpose

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. 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, to include early intervention, prevention, and diversionary supports, to reduce the need for acute and intensive services.

State Context

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.

- 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.

Children and adolescents presenting to hospital emergency departments and inpatient units with behavioral health diagnoses do so within the context of a continuum of services and supports that do not meet their needs in less restrictive settings. Key service gaps identified throughout the stakeholder engagement process include:

- Care coordination
- Support for children and families in Office of Children's Services (OCS)/Division of Juvenile Justice (DJJ) custody
- Access to outpatient behavioral health care for Medicaid-enrolled children and families
- Transitional and navigation support
- Respite care

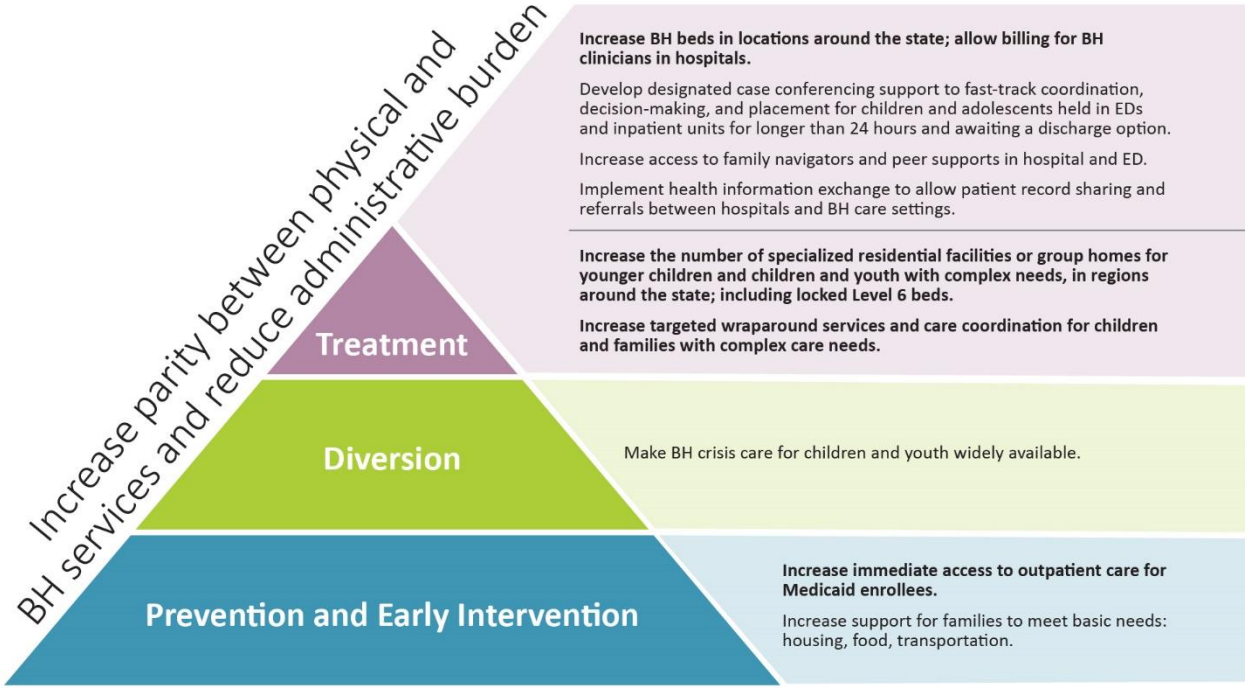
- Limited integration of behavioral health services into school and primary care settings
- Robust crisis services outside of hospital settings
- Specialized residential settings
- Inpatient care

Underlying and exacerbating gaps in care include low payment rates for behavioral health services for Medicaid enrollees, the administrative burden of delivering behavioral health services in a community behavioral health setting, workforce challenges and the financial and human capacity within organizations to start up new programs to fill gaps.

Implementation Workplan

The workplan is organized by three key domains with objectives and action items associated with each. The figure below identifies the objectives under each domain prioritized by the workgroup, with the top priorities in bold. The workplan is intended to be a living document to be used by AHHA, the Trust and other systems change leaders to support the design and implementation of a robust continuum of behavioral health services designed to meet the needs of children, adolescents and their families.

Figure 1: Prioritized Objectives for Building a Robust Continuum of Care



Project Overview

Background

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. Emergency departments are a low barrier, commonly known access point for emergency services, but are not typically designed to meet the needs of individuals experiencing a behavioral health emergency. In 2018 and 2019 the Alaska Hospital and Healthcare Association (AHHA) led efforts to address care for individuals presenting in behavioral health crisis to hospital emergency departments and inpatient settings. The Acute Behavioral Health Improvement Project largely focused on improving care and the continuum of services for adults and provided a roadmap for initiatives and infrastructure to support provider and systems change.

Increasing concerns from 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 to improve acute behavioral health services specific to children and adolescents and address gaps and delays across the continuum of care. 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, to include early intervention, prevention, and diversion supports to reduce the need for acute and intensive services. 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. The priority population for the project are children and adolescents experiencing a behavioral health crisis and the families of those in crisis.

Process and Intended Outcomes

The project considers multi-level solutions that will have a clear, positive impact on child and adolescent behavioral health stays in emergency departments and inpatient units. The primary project outcome is a workplan with objectives and action items that AHHA and project stakeholders commit to implementing and championing. To arrive at multi-level solutions and develop an actionable workplan, AHHA led stakeholders through a learning and planning process that included the following components:

- Review of data from Alaska's Health Facilities Data Reporting (HFDR) program, the Alaska Youth Risk Behavioral Survey, and other national and local sources.
- Development of a shared understanding of the stories behind the data from the perspective of hospital staff and families of children and youth with lived experience.
- Identification of gaps, systemic barriers, and potential strategies to address identified gaps and barriers.
- Prioritization of workplan objectives in three key change areas.

Methodology

Stakeholder Workgroup

AHHA identified stakeholders from among its members and other key partners who informed the development of the work plan and are positioned to help implement the plan. This process relied heavily on the experience and expertise of these stakeholders.

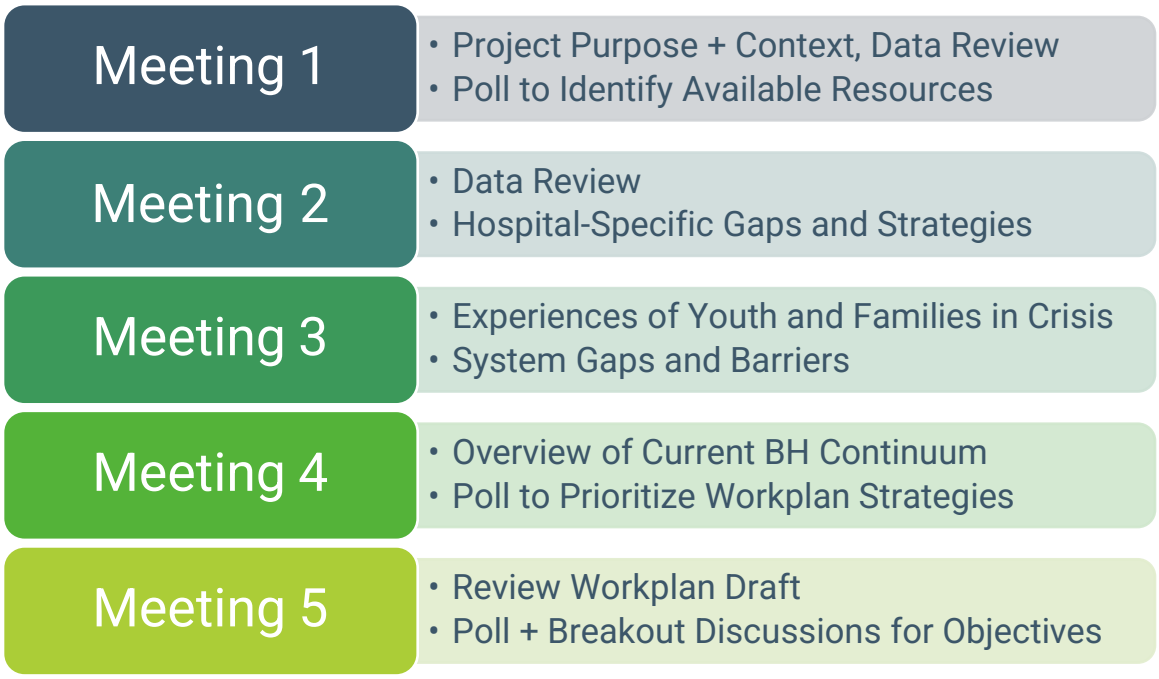
The organizations represented in the stakeholder group include those listed below. Each organization on the list deserves special acknowledgment for the time and staff they set aside to prepare for and attend regular meetings as part of this important project.

Alaska Association of Homes for Children
Alaska Behavioral Health Association
Alaska Children's Trust
Alaska Mental Health Board
Alaska Mental Health Trust Authority
Alaska Native Medical Center
Alaska Native Tribal Health Consortium
Alaska Psychiatric Institute
All Alaska Pediatric Partnership
Anchorage School District
Bartlett Regional Hospital
Central Peninsula Hospital
Denali Family Services
Department of Education
Department of Family and Community Services
Division of Behavioral Health
Division of Juvenile Justice
Division of Public Health
Foundation Health Partners
Maniilaq Association
Mat-Su Health Foundation
Mat-Su Regional Medical Center
North Star Behavioral Health
Norton Sound Health Corporation
Office of Children's Services
Office of the Governor
PeaceHealth - Ketchikan
Providence Alaska
Providence Valdez Medical Center
Samuel Simmonds Memorial Hospital
Southeast Alaska Regional Health Consortium
Southcentral Foundation
University of Alaska Anchorage
Volunteers of America-Alaska
Yukon-Kuskokwim Health Corporation

Workgroup Meetings

The stakeholder workgroup convened five times beginning in March 2022, culminating in workplan development and strategy prioritization sessions in September and November 2022. The figure below provides an overview of topics and activities at each meeting.

Figure 2: Workgroup Overview + Process



Provider Survey, Focus Groups and Interviews

In addition to workgroup meetings, perspectives were gathered from a provider survey, key sector focus groups and interviews with providers and family members with lived experience.

- Between the first and second workgroup meetings, stakeholders were invited to respond to a survey to identify available resources and challenges. Setting-specific questions were asked, with providers selecting from the following options: Hospital (12 responses), Non-hospital provider (5 responses), State of Alaska (8 responses) and Other (4 responses). A summary of survey results can be found in Appendix A.
- Providers representing the key sectors of outpatient treatment, residential treatment and hospitals were invited to participate in focus groups to further explore the strengths, gaps, and barriers in their settings for children and adolescents experiencing behavioral health crisis.
- Ten provider interviews from key sectors or service delivery areas including Tribal health, the Office of Children's Services, the Division of Juvenile Justice, school-based behavioral health service providers, and others. Four interviews were conducted with individuals with lived experience accessing behavioral health services for a family member to inform an understanding of the current system from the family perspective. Informal conversations with two additional families with lived experience also informed the family perspective.

Figure 3: Key sector focus group participants

Prioritization and Workplan Development

To develop the workplan with multi-level strategies, workgroup members prioritized within three strategy areas:

- Prevention, early intervention and diversion
- Behavioral health care in emergency departments and inpatient settings, and
- Treatment and access points for discharge

In the fourth workgroup meeting, participants ranked possible strategies from a pre-identified list, selecting the top three to four strategies in each area. Following the ranking process, the group participated in breakout discussions to identify missing strategies in the key area, barriers and specific changes that could drive improvement. The following questions guided the development and evaluation of potential strategies:

1. How do we reduce the number of children and youth coming to the ED through prevention and early intervention?
2. What other settings could provide immediate care for children, adolescents, and their families to divert them from the ED when in crisis?
3. How do we improve the care provided in medical emergency departments and inpatient settings?
4. What are the treatment and access points for discharge that will help and not harm?

In the fifth workgroup meeting, the group reviewed the potential strategies, now re-worded as objectives in the project workplan, and a draft list of action items associated with each objective. Using the polling tool, stakeholders selected their top objective in each key area. In key area three, two objectives had the same number of votes so both moved forward into the final discussion. In breakout rooms, stakeholders discussed and provided feedback on the prioritized objective and associated action items. Further discussion of the workplan strategy areas, objectives and action items is found in the Finding Solutions chapter. The full workplan, including all action items, is included as an appendix (Appendix B).

Defining the Problem

National Trend: More Children and Adolescents in Behavioral Health Crisis

Escalating adolescent behavioral health needs and psychiatric boarding in hospital emergency departments are areas of rising national concern. A 2020 report from the National Association of State Mental Health Program Directors identified:[1]

- Youth chronic behavioral health disorders have doubled, and now impact 20-25% of youth.
- Suicide is the second most common cause of death in young people.
- People younger than 25 years account for 45% of global disease burden from behavioral health conditions.
- At least 1/3 of ED referrals for youth in behavioral health crisis are not truly urgent.

The U.S. Surgeon General Advisory on Youth Mental Health report noted the following additional trends:[2]

- A 40% increase of persistent feelings of sadness or hopelessness in youth from 2009-2019.
- Depression, anxiety and behavioral problems increased for children and youth between 2016 and 2020.
- In 2019, 36.7% of high schoolers reported persistently feeling sad or hopeless over the past year, and 18.8% seriously considered attempting suicide.
- Suicide was the second leading cause of death among children and adolescents 10-14 years of age and the third leading cause of death for individuals ages 15-24.

Youth and adolescent behavioral health concerns were exacerbated by the COVID-19 pandemic. The White House also noted the impacts of the pandemic on disrupting youth routines and relationships, and that more than half of surveyed parents expressed concern over their children's well-being.[3] The American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and Children's Hospital Association (CHA) declared a national emergency for youth mental health, stating[4]

> "We have witnessed soaring rates of mental health challenges among children, adolescents, and their families over the course of the COIVD-19 pandemic, exacerbating the situation that existed prior to the pandemic…across the country we have witnessed dramatic increases in Emergency Department visits for all mental health emergencies…"

The proportion of mental health-related ED visits in 2021 increased by 24% for children ages 5 to 11 and 31% for those ages 12 to 17 compared to pre-COVID-19 levels.[5] By early 2021, ED visits for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same period in early 2019.[2]

Treatment access is also an issue on a national scale. The 2020 National Survey on Drug Use and Health found that *less than half* of adolescents with a major depressive episode or episode with severe impairment received any treatment.[6] Another study found that publicly insured children or those with no insurance are at higher risk of visiting the ED for a psychiatric reason and posited that this is an effect of challenges in access to outpatient care for those with public or no insurance.[7]

As these and other sources document, the resulting situation in our emergency departments places considerable strain on the system, including patients, their families, healthcare providers, and other staff in the ED, hospital facilities, and the community at large. This latter category includes law enforcement and emergency services personnel, who are often first responders to a person in crisis and must quickly determine whether they need immediate medical attention, and/or present a risk of harm to themselves or others.

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.[8] The state ranked 44th in Economic Well-being, 49th in Education, 44th in Health, and 22nd in Family and Community domains. [8] Among parents and guardians, 50% or more reported concern about obtaining needed items, health care and paying bills.[9] 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.[10] 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.[10] 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.[10] 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.[11] 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.[12]

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.[13] 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.[13] Alaska's youth face challenges at all levels of behavioral health risk and resilience factors.

Figure 4: Alaska Youth Risk Behavior Survey hopelessness and suicide measures

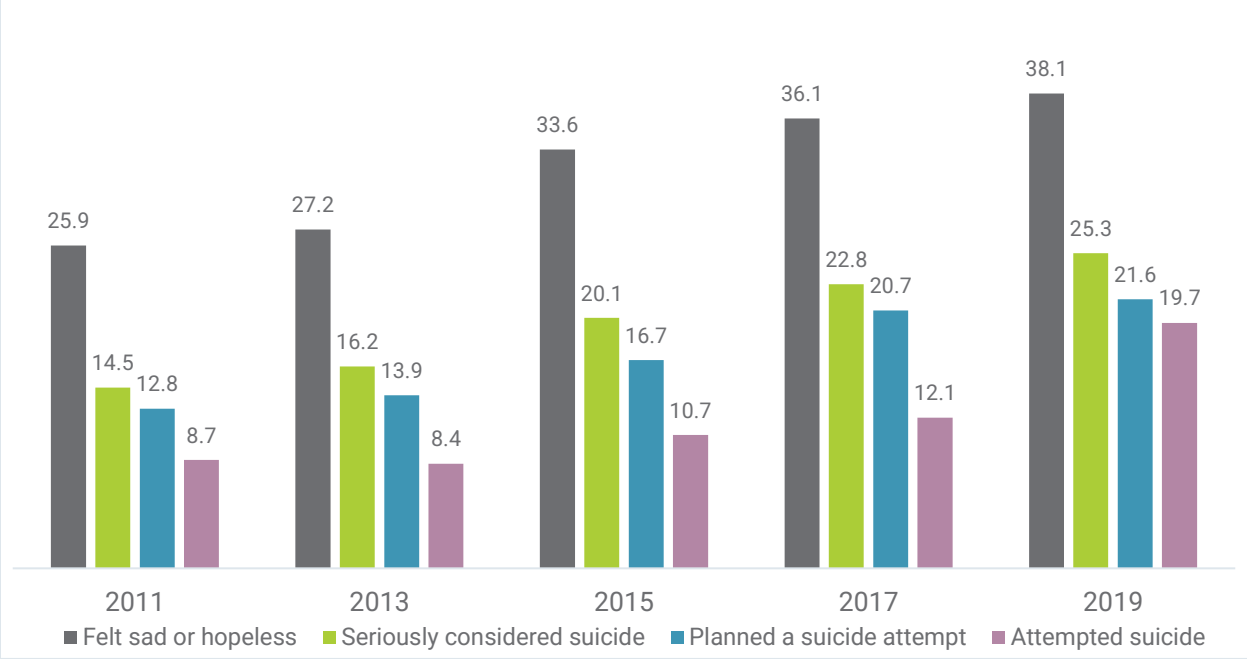
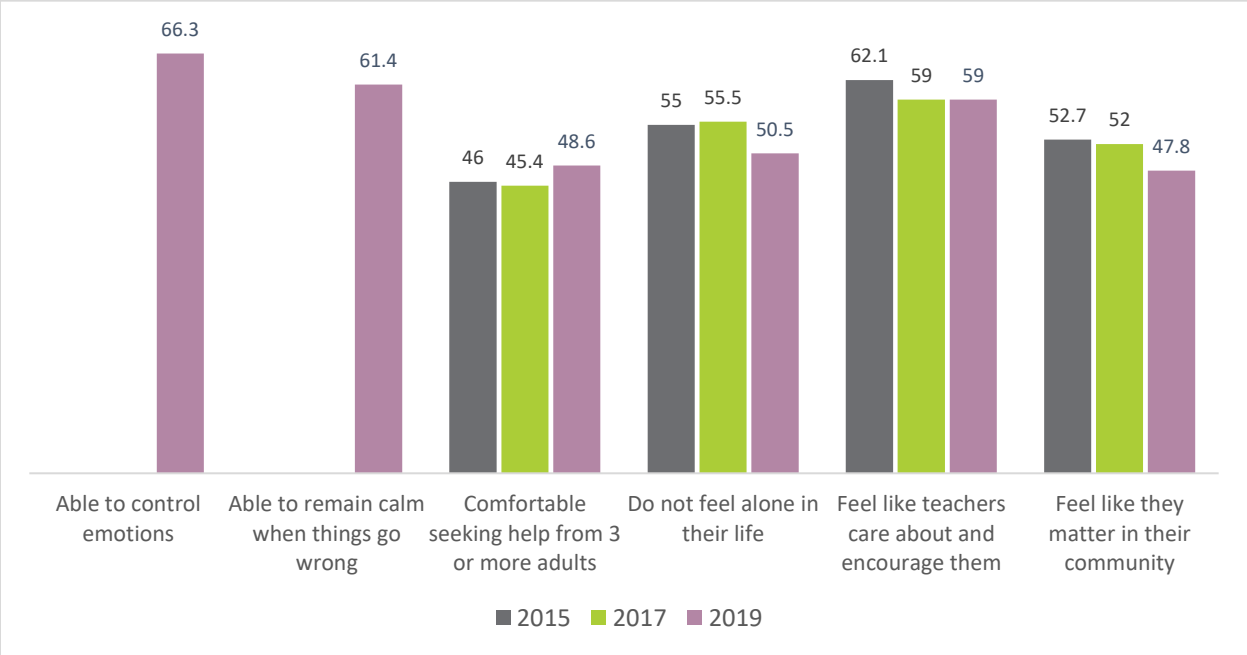


Figure 5: Alaska Youth Risk Behavior Survey connection and resilience-related measures



Quantifying and Characterizing the Problem: Review of Alaska Data

Methodology

The Alaska Health Facilities Data Reporting Program (HFDR) collects inpatient and outpatient discharge data for Alaska healthcare facilities and catalogs them in the Alaska Inpatient Database or the Alaska Outpatient Database. Discharge data shows the utilization of health services and provides evidence of the conditions for which people receive treatment. Alaska's system was developed in 2001 as a voluntary program, with hospitals agreeing to report inpatient discharge data based on claims information; outpatient discharges, including emergency department visits, were added in 2008.

To define a "behavioral health utilization" of emergency department and inpatient settings, data was requested from HFDR based on the criteria used in a similar data pull that informed the 2018 Acute Behavioral Health Improvement Project. "Behavioral health" includes episodes with any of the following diagnosis types:

- **F* series:** Mental, behavioral, and neurodevelopmental disorders
- **R45.850:** Homicidal ideation
- **R45.851:** Suicidal ideation
- **R41.82:** Altered mental status

The diagnosis codes identified could be primary or secondary (in any position, up to 30). Unless otherwise identified, data is for children and adolescents ages 0-17. For data where hours are calculated, some facility data is excluded as hours were not reported. Data presented in this report is for calendar years 2019, 2020 and 2021 (2019 version 5, 2020 version 2 and 2021 version 1 datasets). Results from 2021 are provisional.

Key Findings: Hospital Emergency Department and Inpatient Settings

HFDR data provides a numerical understanding of the volume, characteristics and support needs of children and adolescents presenting to hospitals for behavioral health needs.

- 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.

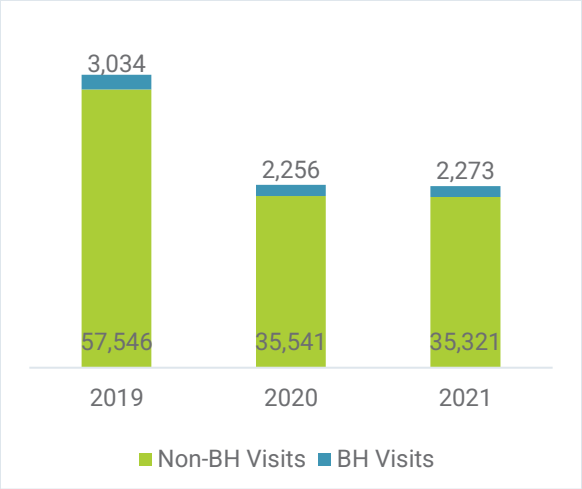
The data, paired with the on-the-ground experiences of Alaska providers, provides an understanding of the provider, patient and family experiences behind the numbers.

Utilization

Volume

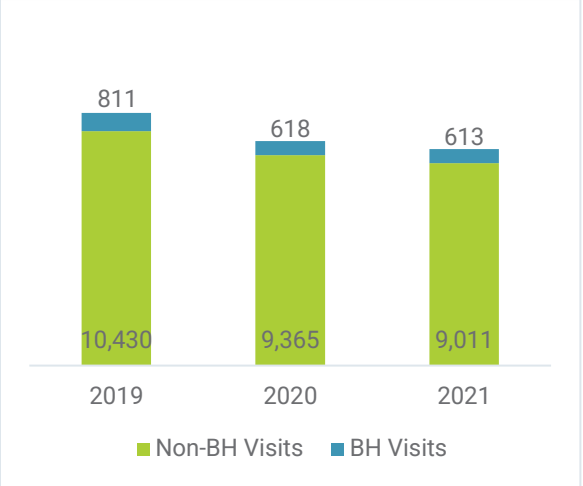
ED visits for children and adolescents without a behavioral health diagnosis decreased from 57,546 to 35,541 in 2020, a 38% decrease. ED visits for this age group with a behavioral health diagnosis decreased from 3,034 in 2019 to 2,273 in 2021, a 26% decrease (See Figure 6). ED visits regardless of diagnosis stabilized between 2020 and 2021. While visits of all types saw significant decreases, the dip in visits was proportionally less for children and adolescents with a behavioral health diagnosis than those without. ED visits with a behavioral health diagnosis, as a percentage of the total, increased slightly, from 5% to 6% between 2019 and 2020.

Figure 6: Total ED visits ages 0-17 years



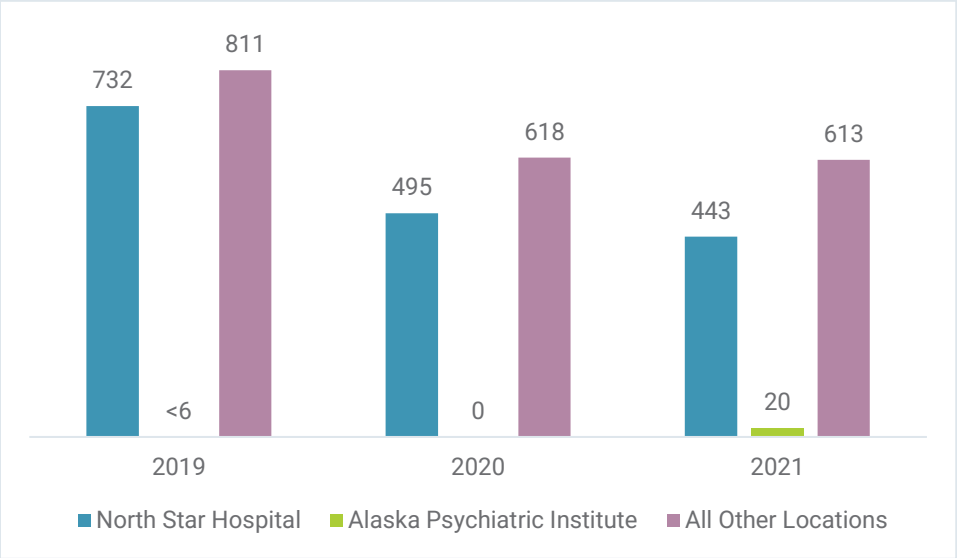
Inpatient admissions for children and adolescents without a behavioral health diagnosis decreased from 10,430 in 2019 to 9,365 in 2020, a 10% decrease. Behavioral health inpatient visits for this age group also decreased from 811 in 2019 to 613 in 2021, a 24% decrease (See Figure 7). Inpatient admissions regardless of diagnosis stabilized between 2020 and 2021. Stakeholders suggested that the decrease in admissions to inpatient units for children and youth with a behavioral health diagnosis was related to staffing shortages and decreased bed availability, rather than decreased need. Inpatient visits with a behavioral health diagnosis, as a percentage of the total, decreased slightly, from 7% to 6% between 2019 and 2020.

Figure 7: Total inpatient visits ages 0-17 years



When compared with Alaska's two inpatient psychiatric facilities for children and adolescents (North Star Hospital and the Alaska Psychiatric Institute), hospital inpatient units (identified as all other locations in Figure 8), consistently see a higher volume of admissions for children and adolescents with a behavioral health diagnosis.

Figure 8: Inpatient Admissions by Facility, Ages 0-17



Length of Stay

Most children and adolescents with behavioral health visits to the ED discharge within 12 hours (Figure 9).[1] However, the number of children and adolescents with stays of 12 hours or longer and the percentage of stays of longer lengths are increasing. In 2021, 16% of child and adolescent ED stays were longer than 12 hours, up from 10% in 2019. The greatest increases occurred for stays of 36+ hours. In 2019, just 51 children and adolescents remained in emergency department beds for longer than 36 hours. By 2021, that number increased to 84.

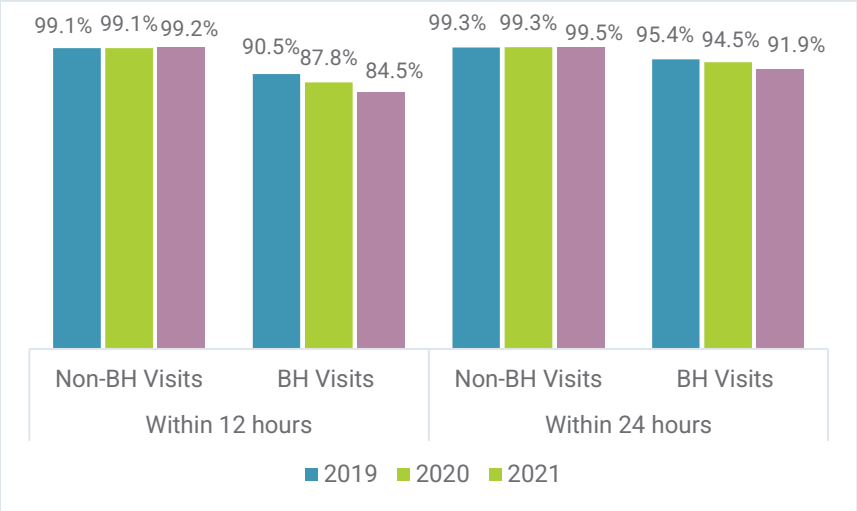
Figure 9: Youth Behavioral Health Lengths of Stay in Emergency Departments

	Number of Visits					Percent of Visits				
Year	**0-11 hours**	**12-23 hours**	**24-35 hours**	**36+ hours**	**12+ hours**	**0-11 hours**	**12-23 hours**	**24-35 hours**	**36+ hours**	**12+ hours**
2019	1,883	102	45	51	**198**	90%	4.9%	2.2%	2.5%	**10%**
2020	1,349	102	42	43	**187**	88%	6.6%	2.7%	2.8%	**12%**
2021	1,414	125	51	84	**260**	84%	7.5%	3.0%	5.0%	**16%**

Compared to their ED counterparts without a behavioral health diagnosis, children and adolescents with a behavioral health diagnosis are less likely to discharge within 12 and 24 hours. While nearly all children and adolescents without a behavioral health diagnosis discharge within 24 hours (99%), only 91.9% of those with a behavioral health diagnosis did in 2021 (Figure 10).

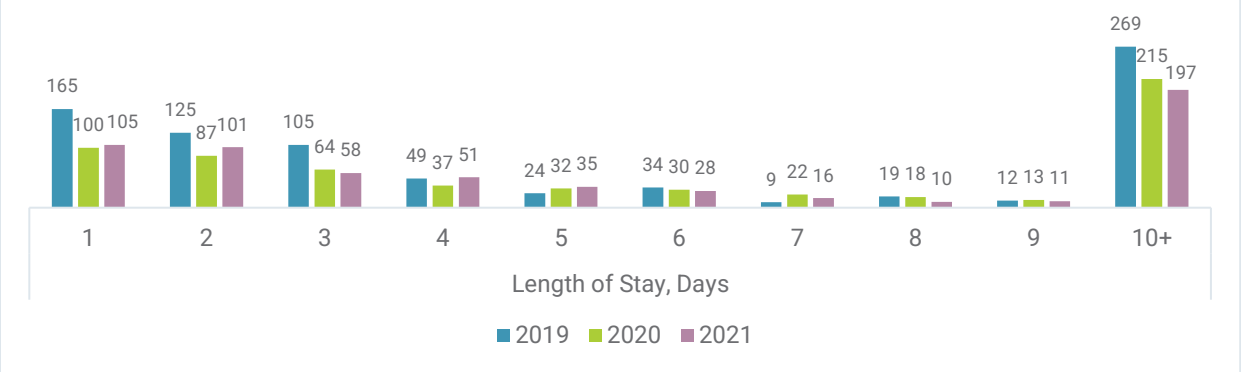
[1] The visit totals in Figure 9 by hours do not sum to the total of all visits as described in Figure 6 because three hospitals do not submit hours for ED visits. Excluded facilities are Fairbanks Memorial Hospital, Yukon Kuskokwim Delta Regional Hospital, and Samuel Simmonds Memorial Hospital (Bristol Bay Area Health Center and Wrangell Medical Center are also excluded for 2019 only).

Figure 10: Youth ED Visits Discharged at 12 and 24 hours



Children and youth admitted to an inpatient unit with a behavioral health diagnosis experience a range of stay lengths with roughly one-third discharged within two days, one-third discharging within 3 to 9 days, and the remaining third experiencing stays of 10 days or more (Figure 11). Many stakeholders shared stories of children and youth with complex care needs remaining on hospital inpatient units for weeks or months awaiting an appropriate residential treatment placement.

Figure 11: Youth Behavioral Health Length of Stay (days) in Inpatient Units



Characteristics

Age and Gender

Adults aged 18 and older comprise 97% of all ED visits with a behavioral health diagnosis and 96% of all inpatient admissions with a behavioral health diagnosis. While children and adolescents comprise just 3-4% of total visits with a behavioral health diagnosis, the impact on hospital staff, patients and families is significant.

The total number of inpatient admissions visits by children and adolescents with a behavioral health diagnosis increases with age. Over half of all inpatient behavioral health visits are for female adolescents ages 12-17 years (Figure 12). Behavioral health ED visits demonstrate similar trends with over half of visits by female adolescents ages 12 to 17, while patients under the age of 12 are more likely to be male (Figure 13).

Figure 12: BH Inpatient Admissions by Age and Sex (2019-2021 average)

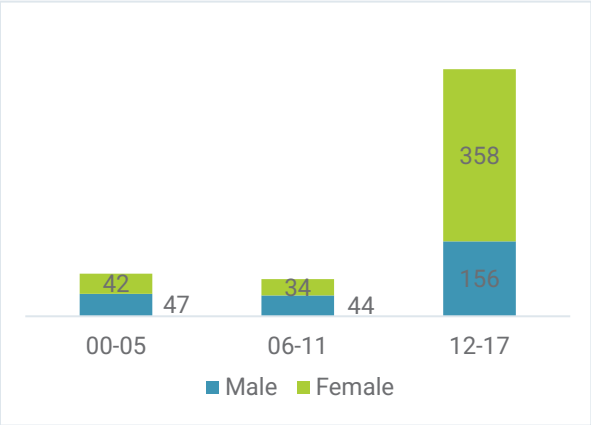
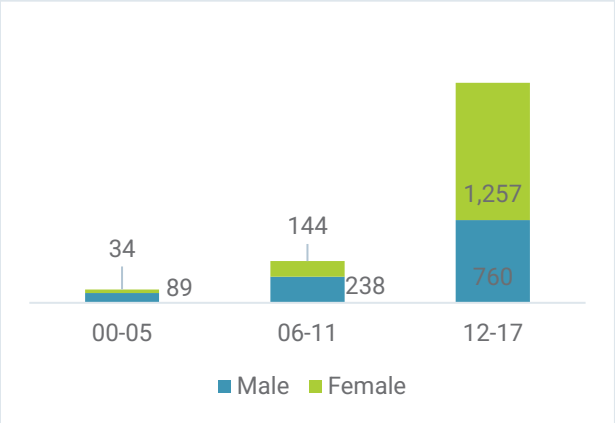


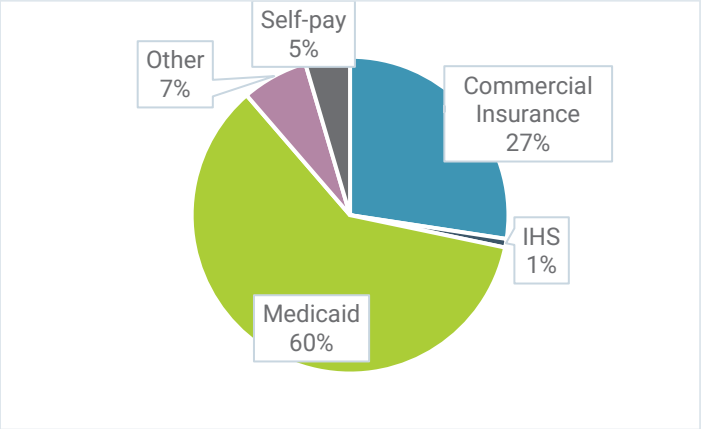
Figure 13: BH ED Visits by Age and Sex (2019-2021 average)



Insurance

A significant portion of children and youth seen in the ED with a behavioral health diagnosis are enrolled in Medicaid. In 2021, just over 60% of all youth BH visits to the ED had Medicaid as the primary payor. This percentage corresponds with the percentage of children in Alaska with Medicaid coverage, estimated at 57%.[2] Less than 30% of youth were insured commercially, and nearly 5% were self-pay (Figure 13).

Figure 14: Youth ED BH Visits, by Payor (2021)

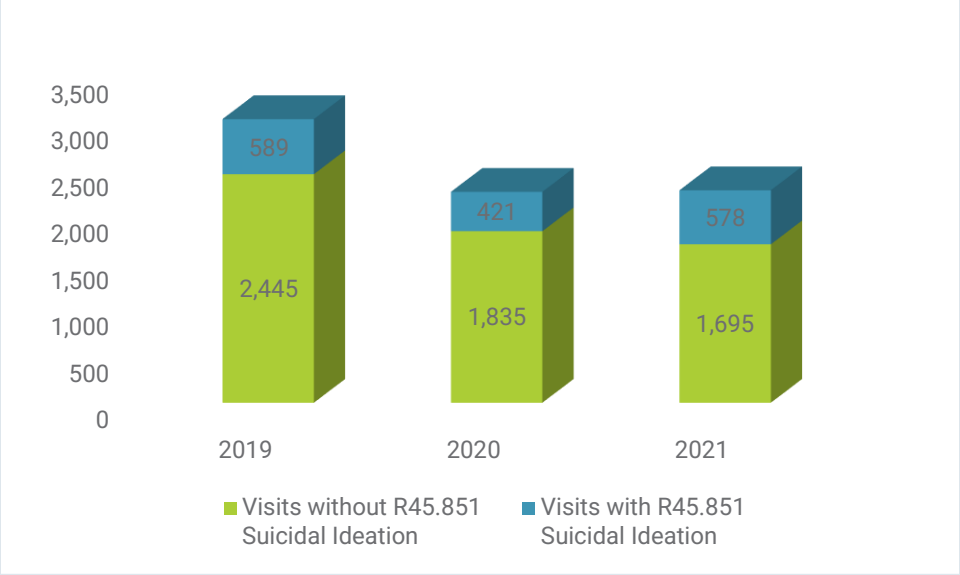


Diagnosis

R45.851 - Suicidal Ideation was identified as a discharge diagnosis in 19% of all ED visits with a behavioral health diagnosis in 2019 and 2020, rising to 25% of all ED visits with a behavioral health diagnosis in 2021 (n = 578, Figure 15). A visit with suicidal ideation identified may also have an F series diagnosis (Mental, behavioral, and neurodevelopmental disorders) associated with the discharge.

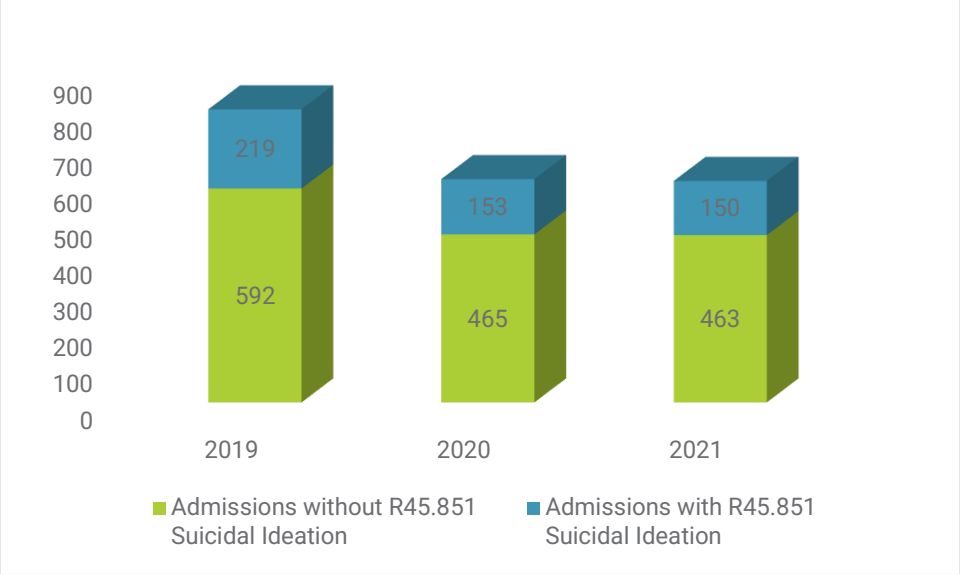
[2] U.S. Census data estimates place the total population under 18 years in Alaska at 179,505 youth in 2021 and CMS enrollment highlights indicate child enrollment numbers for Medicaid and CHIP programs at 104,813 in 2022.

Figure 15: ED Visits with and without Suicidal Ideation as a Discharge Diagnosis



While the proportion ED visits with R45.851 - Suicidal Ideation as a discharge diagnosis increased between 2019 and 2021, the number and proportion of inpatient admissions with this diagnosis decreased over the same period. Suicidal Ideation was identified as a discharge diagnosis in 27% of all inpatient admissions with a behavioral health diagnosis in 2019, 25% in 2020 and 24% in 2021 (n = 150, Figure 16). An admission with suicidal ideation identified may also have an F series diagnosis associated with the discharge.

Figure 16: Inpatient Admissions with and without Suicidal Ideation as a Discharge Diagnosis



Each of the F series diagnoses was grouped into the categories below. A child or adolescent is counted only once in each category per visit, even if they had more than one F series diagnosis. The diagnosis categories are rank ordered as listed below, so if a discharge included both a diagnosis in the episodic mood disorders category and the drug dependence category, the visit would only be counted in the episodic mood disorders category. In the data pull, diagnosis categories were tied to

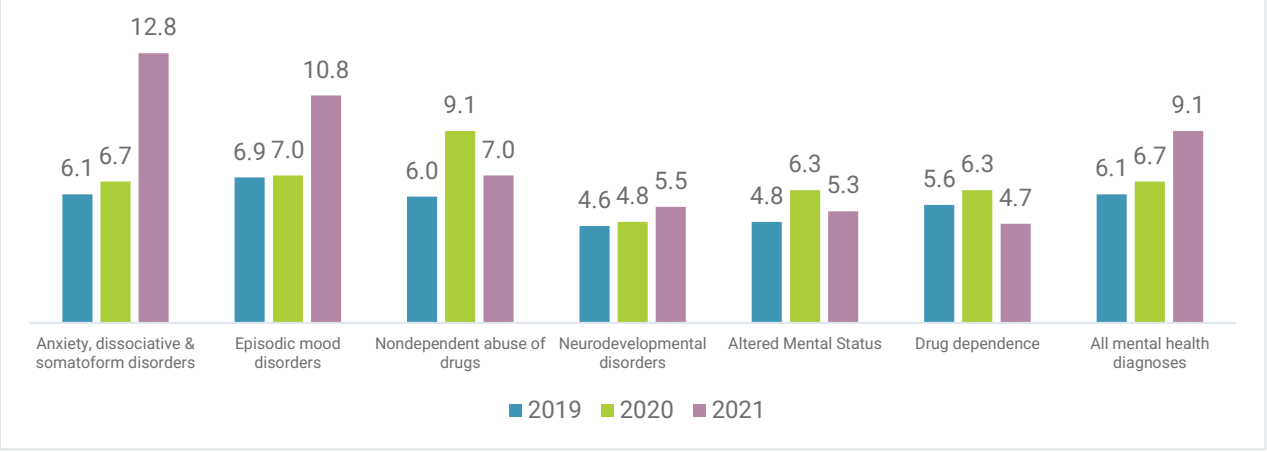
hours spent in the ED. Because not all hospitals report hours, not all ED visits are included in the table below. While the methodology of the data pull obscures a full picture of diagnostics for children and youth presenting to emergency departments, three categories – Anxiety, dissociative and somatoform disorders, neurodevelopmental disorders, and episodic mood disorders rise to the top as diagnoses for both ED visits and inpatient admissions (Figure 17).

Figure 17: Diagnosis category prevalence for ED and Inpatient visits, 2021

Diagnosis Category by Rank Order (each episode counted in only one category)	BH ED Visits N=1,674	BH Inpatient Admissions N=613
Schizophrenic Disorders	<6, cannot calculate	<6, cannot calculate
Episodic Mood Disorders	**17%**	**14%**
Neurodevelopmental Disorders	**24%**	**26%**
Delusional Disorders	<6, cannot calculate	<6, cannot calculate
Other Nonorganic Psychoses	<6, cannot calculate	<6, cannot calculate
Anxiety, Dissociative and Somatoform	**24%**	**36%**
Alcohol Dependence Syndrome	<6, cannot calculate	<6, cannot calculate
Drug Dependence	5%	4%
Nondependent Abuse of Drugs	8%	10%

Emergency department length of stay is variable within the top diagnostic categories. The most profound change in length of stay was for children and adolescents with an anxiety, dissociative or somatoform disorder. Visits within this diagnostic category increased by 110% from 6.1 hours in 2019 to 12.8 hours in 2021 (Figure 18). The length of stay for all F series diagnoses and altered mental status increased 49% from 6.1 hours in 2019 to 9.1 hours in 2021. Diagnosis categories with fewer than six visits in all or most of the past three years are excluded from the table below (Schizophrenic Disorders, Delusional Disorders, Other Nonorganic Psychoses, Alcohol Dependence Syndrome).

Figure 18: Average hours in ED by diagnosis category



Variations in length of stay are also seen for children and adolescents admitted to behavioral health inpatient units. Those in the diagnosis categories of anxiety, dissociative and somatoform disorders, delusional disorders, and drug dependence have the longest stays on hospital inpatient units compared to the average length of stay for all diagnoses (Figure 19).

Figure 19: Average days on inpatient unit by diagnosis category

Diagnosis Category	Average Days on Inpatient Unit, 2019-2021
All Diagnosis Categories	9.1 days
Schizophrenic Disorders	4 days (Note: No visits in this category in 2019 or 2020)
Episodic Mood Disorders	7.1 days
Neurodevelopmental Disorders	7.4 days
Delusional Disorders	**23.7 days**
Other Nonorganic Psychoses	6.3 days
Anxiety, Dissociative and Somatoform	**11.7 days**
Alcohol Dependence Syndrome	1 day (Note: No visits in this category in 2019 or 2021)
Drug Dependence	**10.5 days**
Nondependent Abuse of Drugs	7.9 days

Discharge Status

Most youth in the ED or inpatient units for behavioral health needs discharge to home/self-care. Over 90% of ED visits (Figure 20) and nearly 80% of inpatient visits (Figure 21) discharge back to their home setting, with much smaller percentages discharging to psychiatric hospital units or to other settings.

Capacity at inpatient psychiatric units, rather than demand for these beds, may be the more important driver of low discharge rates to these settings. Stakeholders shared experiences where youth remain so long in inpatient medical units that they stabilize to a point where they no longer need inpatient psychiatric care (but have not yet received any behavioral health focused care). Additionally, it is unclear from the data and the categories available how hospitals categorize individuals who discharge to a residential placement. Lack of a specific category for residential behavioral health care obscures how many children and adolescents are discharged to these settings, which were also indicated as a highly needed discharge resource for hospitals.

Figure 20: Youth BH ED discharge disposition

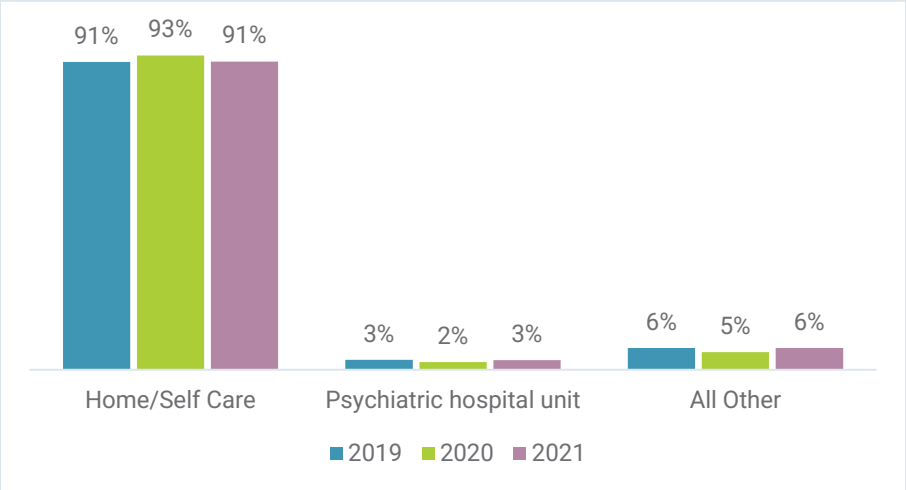
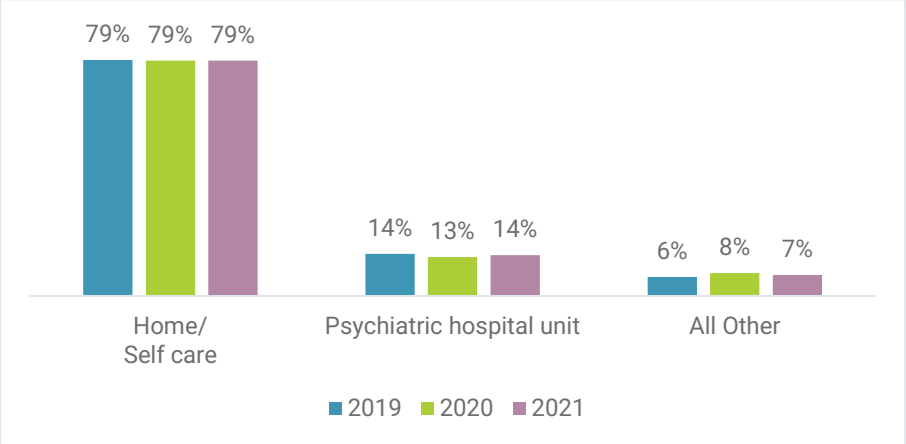


Figure 21: Youth BH inpatient discharge disposition

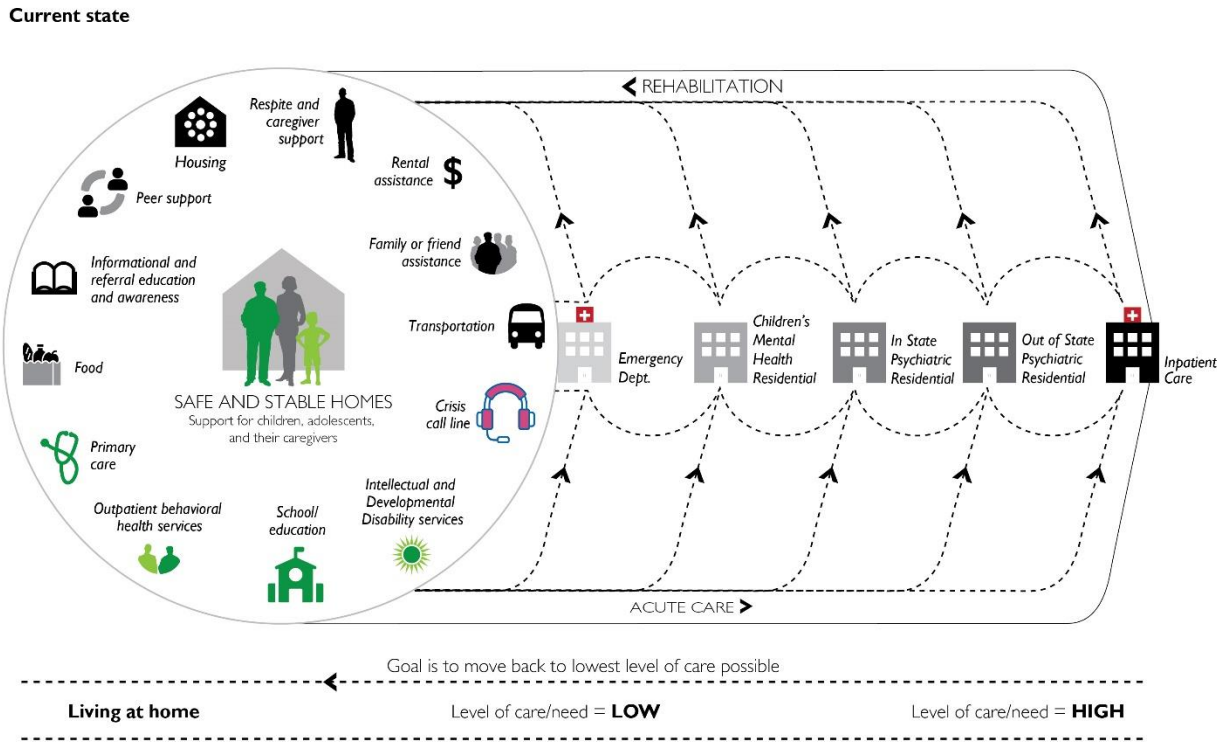


Alaska's Continuum of Care for Children and Adolescents

Alaska's current continuum of care for children, adolescents and families is fragmented. A United States Department of Justice Civil Rights Division Investigation of the State of Alaska's Behavioral Health System for Children found that there is reasonable cause to believe the State is violating the Americans with Disabilities Act by failing to provide appropriate treatment options. Furthermore, the investigation found that Alaska children experience unnecessarily long stays at inpatient psychiatric and residential psychiatric facilities due to a lack of community-based treatment options.[14]

Drawing from available data, the knowledge of workgroup, focus group and interview participants, and prior studies, helps form an understanding of the current continuum. Prevention, early intervention, and outpatient supports exist but are not connected and coordinated in a meaningful way for most individuals. Behavioral health crisis care is primarily provided in hospital emergency departments, which increasingly struggle to find residential and inpatient treatment options for children and adolescents who need higher levels of care, and are often unable to meaningfully connect individuals to outpatient treatment and supports when a higher level of care is not warranted. Figure 22 depicts the current continuum of care for children and adolescents.

Figure 22: Continuum of Care, Current State



Key service gaps identified throughout the stakeholder engagement process include:

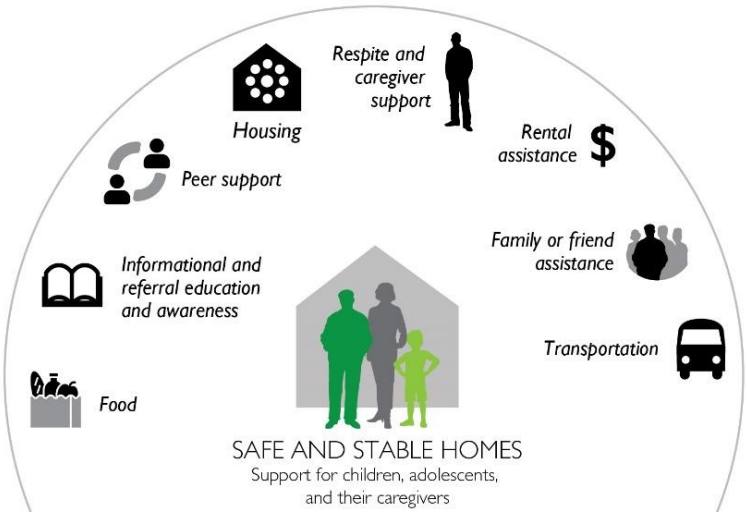
- Care coordination
- Support for children and families in OCS/DJJ custody
- Access to outpatient behavioral health care for Medicaid-enrolled children and families
- Transitional and navigation support
- Respite care
- Limited integration of behavioral health services into school and primary care settings
- Robust crisis services outside of hospital settings
- Specialized residential settings
- Inpatient care

Underlying and exacerbating gaps in care include low payment rates for behavioral health services for Medicaid enrollees, the administrative burden of delivering behavioral health services in a community behavioral health setting, workforce challenges and the financial and human capacity within organizations to start up new programs to fill gaps.

> "We talk about building a continuum of care but more often it is a funding issue, and we short-change part of the continuum: we want early intervention so we short-change the higher level. **We will always need the whole continuum**."
>
> *~ Residential provider focus group participant*

Prevention and Early Intervention

Support for children, adolescents and their caregivers is foundational to healthy homes. Supports include basic resources like housing, food, and transportation as well as respite care and targeted supports for at-risk and hard to engage families. As one focus group participant shared "We could really decrease the need for higher levels of care if we engaged families earlier". Engagement requires a special skillset and is time-consuming – "We might go 12 times before the parent lets you in" – and unless contact is made and a service is provided, providers are not reimbursed for the time it takes to engage a family.



"80% of families we serve are involved with OCS. We could reduce the number of children going into foster care by 50% if we improved housing and food security, transportation…"

– Outpatient provider focus group participant.

Stakeholders highlighted a need for respite care for children and youth. In the current continuum, respite care is not a reimbursable service and therefore is not readily available to youth and families that could benefit from this service.

Outpatient and Integrated Care

When considering potential drivers for increasing need for higher level behavioral health interventions, access to lower levels of care requires serious attention. HFDR data shows that 60% of youth with a behavioral health diagnosis have Medicaid identified as the payer source and over 55% of Alaskan children are enrolled in Medicaid,[3,15,16] yet a large portion of the behavioral health workforce (individuals in private practice) do not accept Medicaid.

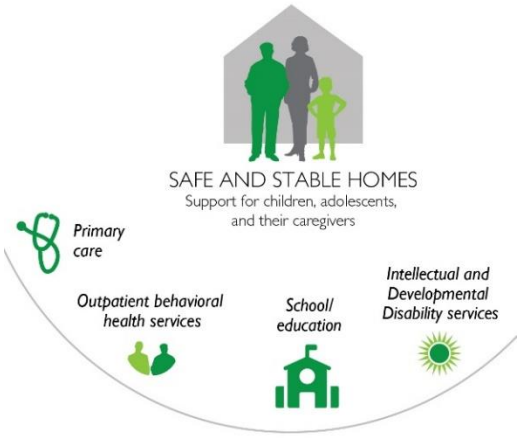
A scan of providers listed on Psychology Today's provider search, which largely represents providers in private practice, identified 380 providers in Alaska, of which only 11 indicated they accept Medicaid.[18] The Substance Abuse and Mental Health Services Administration Locator Map identifies 248 substance use and mental health treatment facilities in Alaska, but does not provide additional information regarding provider availability. OpenBeds Treatment Connection platform is used in Alaska but is not regularly updated. Alaska's Administrative Service Organization (ASO) for behavioral health, Optum, has two care coordinators and one peer support specialist. However, their services are currently only available for adults, and they are only able to contact someone for follow up if a referral is made or after a claim is received. Lack of unified systems for finding available providers and appointments makes it challenging to truly assess system capacity and is a barrier for ED and inpatient providers who wish to connect children and youth with follow-up care. While quantifying the number of available appointment slots and the demand for those slots is not possible with currently available information, stakeholders consistently report challenges accessing outpatient appointments, with one provider reporting they were told of a waitlist of over 900 individuals, others sharing that the wait is often 12-18 months.

The education system is increasingly recognized for its vital role in providing access to behavioral health care for children and youth. A recent two-part assessment, Mental Health Supports in Alaska's Schools, demonstrates how schools and districts across the are responding to student need through an array of funding streams, approaches, and partnerships. Integrating behavioral

[3] U.S. Census data estimates place the total population under 18 years in Alaska at 179,505 youth in 2021 and CMS enrollment highlights indicate child enrollment numbers for Medicaid and CHIP programs at 104,813 in 2022.

health services into school settings requires strong collaboration between the State of Alaska Department of Education and Early Development and the Department of Health and the Mental Health Supports assessments provide a starting point for continued efforts.[19]

Children and adolescents with complex needs are often met with siloed care. As one provider stated, "The service system is not incentivized to intersect with the school environment…they [children and youth with behavioral health and IDD needs] fall further and further behind". Interlocking supports for youth with co-occurring IDD and behavioral health needs are not readily available and accessing comprehensive care requires sizable effort by the family or a care coordinator. Stakeholders noted efforts to better integrate behavioral health with primary care, schools, and intellectual and development disability (IDD) services are underway, but more focus is needed to support children and adolescents in the setting that best meets their needs and with a fully array of interconnected services.



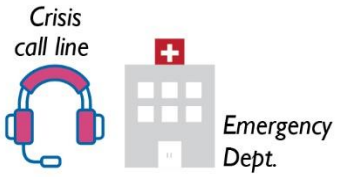
Efforts to support integration of behavioral health into different services and settings highlighted by stakeholders are described below. These efforts are important components of system change and increased connectivity.

Primary Care: The Partnership Access Line – Pediatric Alaska (PAL-PAK) offers immediate support to pediatric care providers in Alaska who have questions about child and adolescent mental health care, including diagnostic clarification, medication adjustment and treatment planning. The consultation line is staffed by psychiatric providers at Seattle Children's Hospital and is available free of charge. Help Me Grow Alaska provides additional resource and navigation support to families and providers who access the line.[18]

Schools: The Alaska Mental Health Trust Authority released a two-part report to understand the current landscape of mental health supports in schools and to inform efforts by districts, and local and state policy makers to improve student mental health via school-based interventions.[19]

IDD: The University of Alaska Anchorage Center for Human Development received a five-year grant to develop a training for helpers of individuals with mental health and IDD support needs. Initial sessions for stakeholders to learn about the grant and set a course for training program development were held in June 2022.

Behavioral Health Crisis Care

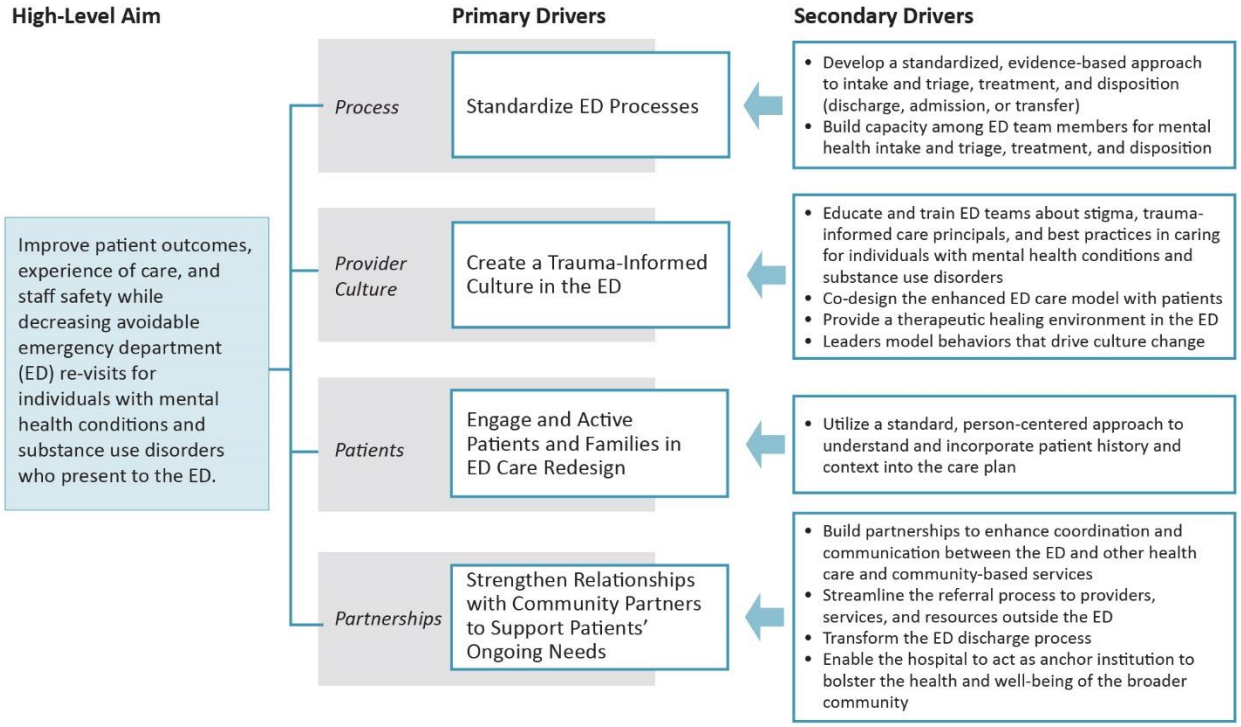


Statewide access to behavioral health crisis services is limited to one resource – the Alaska Careline. From 2017-2019, just 2% of Careline's 55,298 callers were between 15-17 years old. This age group represents 4% of Alaska's population.[20] To date, providers report limited implementation of 1115 Waiver crisis services specifically for youth (mobile crisis and outreach response, 23-hour crisis observation and stabilization, crisis residential and stabilization). Where mobile crisis teams exist, youth make up a small proportion of individuals served. Outpatient and residential providers report that when they refer children and families to the emergency department they are seeking 1) safety, 2) decompression space for the child and family 3) a second opinion on a level of care assessment and 4) help securing a referral. Without behavioral health crisis services for providers to refer to, emergency departments become the de facto settings for safety, further assessment, and referrals to higher levels of care.
The moral injury faced by providers at all levels in the continuum is evident. As one provider expressed, "You feel powerless because people are coming to you for help and you have to say 'sorry you have to take your violent child home today and call 9-1-1' – what a terrible option".

Hospital Efforts

Hospital focus group participants shared that hospital emergency departments and inpatient units have done much to address the Institute of Healthcare Improvement (IHI) framework drivers in the three years following the Acute Behavioral Health Improvement Project (Figure 23). Provider responses to a poll in the first workgroup meeting also indicated that more resources are available in emergency department settings than in years past. Of the 15 hospital providers who responded, the most common resources available were psychiatric evaluations and/or consultations (73%) and verbal de-escalation training for staff (67%). Other common resources were standardized screening tools to identify patients with behavioral health needs, and behavioral health assessments provided by a clinician (60% each). Less common resources included dedicated rooms for behavioral health patients (53%), family or advocate involvement in care plan development (20%) and standing orders for psychiatric medication (13%). Thirteen percent of respondents indicated none of the resources described were available in their emergency department.

Figure 23: Institute of Healthcare Improvement (IHI) Framework Drivers [21]



Hospital providers acknowledge that more can be done, but the system issues persist. Notably:

- The most complex, traumatized children and youth have few to no options and are sometimes abandoned at hospitals. With limited in and out of state options, these children and youth often remain in hospital settings with limited treatment for days or weeks. If a child or youth in this situation assaults a staff member, s/he may be charged and transferred to a correctional setting where treatment is also very limited.
- Access to patient records across providers is limited and hampers continuity of care.
- Children and adolescents in OCS custody are most likely to languish in hospital ED and inpatient settings.
- Hospitals are experiencing high staff turnover and nursing shortages. Staff strain is exacerbated by patients with behavioral health issues whose treatment needs cannot be met in the hospital setting but who have nowhere else to go.
- Hospitals struggle to find and access inpatient and residential treatment for children and adolescents who need these higher levels of care.

While hospitals are working to tailor care to meet the needs of their patients, the resources they have often do not match the level of support providers and families seek when they present at an emergency department with behavioral health needs.

Residential Behavioral Health Treatment

Alaska's infrastructure for residential behavioral health treatment was the subject of the Bring the Kids Home initiative, which focused statewide from 2004 to 2012 to reduce the number of Alaska children with severe emotional disturbances being sent to out-of-state residential psychiatric

treatment facilities. As a result of Bring the Kids Home planning, capacity development, management and policy shifts, and the investment of new resources, the initiative was successful at reforming Alaska's behavioral health system of care for children and adolescents. Over time, fewer children received Medicaid-funded out-of-state mental health treatment, and there was a significant decrease in recidivism to residential psychiatric treatment centers (within one year) with new supports available to support children and their families in the community.

A 2019 conference revisited data for children and adolescents in out of home care settings and found the number of Alaska youth in out-of-state residential psychiatric treatment facilities was again on the rise, with 254 youth in out-of-state treatment in FY 2018, up from 112 in FY 2013.[12] More recent data indicates a significant decrease, with a monthly average of out-of-state placements of 149 in January 2019 and 80 in January 2022.[22] However, stakeholders report challenges accessing residential treatment for children and adolescents both in and out-of-state and believe the decline is driven by lack of capacity rather than lack of need. The number of beds at in-state psychiatric residential treatment facilities remains unchanged since 2019, with 121 beds in four facilities.

The Medicaid State Plan code for Behavioral Rehabilitation Services sunsetted at the end of June 2021. Providers offering residential services using this code either discontinued billable services or transitioned to new services such as the 1115 Waiver service Children's Mental Health Residential Treatment Levels 1 and 2. At the time of this writing, it is unclear if this transition impacted the number of beds available for in-state residential treatment. It is also unclear how many in-state residential beds exist, what the current capacity is, and how COVID-19 precautions and workforce challenges are impacting availability.

Complex Care

In-state residential psychiatric treatment facilities often do not have the capacity to serve the most complex individuals, with documented exclusionary criteria for patients with co-occurring behavioral health needs such as intellectual disabilities, eating disorders, severe autism, sexual offenses, elopement risk, psychosis, or fire setting.[23] Only one of Alaska's four facilities is authorized to lock doors, which providers report poses challenges for patient safety and limits the acuity of individuals they can accept. Data from FY 2016-2018 identified that youth with risk factors for aggression, treatment non-compliance, and property destruction were more likely to receive residential treatment out-of-state.[12] Children and adolescents with neurodevelopmental disorders and mood disorders were also more likely to be sent out of state for treatment.[12] Division of Juvenile Justice staff report that out-of-state residential placements are requesting continued DJJ involvement for aggressive

> "Families are at their wits end. If we can't get a child to a placement, they won't come and pick their child up. We have kids abandoned in our hospital and OCS won't open a case because the child is 'safe' in the hospital."

youth, which was not required as frequently in the past. Similarly, OCS reports more denials from out-of-state treatment providers. The coupling of stagnant or decreased capacity in-state and a decrease in out-of-state capacity for the children and youth with the most complex needs presents challenges for hospitals and the juvenile justice system who are required to accept all who are referred to them.

The Office of Children's Services and behavioral health providers are often tasked with quickly trying to respond to a wide variety of treatment needs that might include a young child with low cognitive functioning who is self-harming and a teenager with a conduct disorder who attempted to burn down a home. Alaska does not have the necessarily robust system to appropriately support a wide range of needs in residential care. Lack of availability in existing residential services often means a child is admitted to the first available bed and not to the treatment facility that will best meet their needs.

One provider shared that the larger residential units that are most readily available in the state are not conducive to meeting the complex needs of children and adolescents. A large unit with many children and youth with similar diagnoses and level of acuity can escalate quickly. This provider reported that a youth who may be very acute in a large unit, when placed on a smaller, more calm unit, often does much better.

Inpatient Behavioral Health

Alaska Psychiatric Institute (API) has a capacity for 80 beds, but only 10 beds are designated for adolescents (Chilkat Unit), and this unit closed for almost a year before reopening in 2021. Admissions at North Star Hospital, the only facility available for children under 13 years, decreased from 732 in 2019 to 333 in the first three quarters of 2021. There have been growing concerns that understaffing and staff turnover at North Star Hospital are leading to inadequate patient supervision and inappropriate staff-to-patient ratios, contributing to a rise in unsafe patient conditions including patient elopement and accusations of sexual assault.[24] During a six-month period in 2022, law enforcement was called to the campus on 71 separate occasions, compared to only 34 times in the same period of the previous year.[25] The facility also received a "preliminary denial of accreditation" from The Joint Commission on November 2nd, 2022 with additional documented concerns from other regulators from the state Division of Behavioral Health and the Centers for Medicare & Medicaid services.[25] The lack of statewide capacity at behavioral health inpatient-level care settings increasingly tasks hospitals with meeting the behavioral health needs of youth and their families who have no other options.

Across the Continuum

1115 Medicaid Waiver

The 1115 Medicaid Waiver was designed to create a more robust continuum of behavioral health services with an emphasis on early intervention, community-based outpatient, residential treatment and peer recovery supports for three priority populations: 1) Children, adolescents and their parents or caretakers with, or at risk of, mental health and substance use disorders; 2) Transitional age youth and adults with acute mental health needs; and, 3) Adolescents and adults with substance use disorders. While stakeholders agree the services in the 1115 Waiver are much needed, the product of the Waiver – new programs that support children and adolescents in community – have yet to be

fully realized. While more individuals of all ages received 1115 services between State Fiscal Year (SFY) 2021 and 2022 the total number of clients served per quarter is not increasing.[22]

Providers and interviewees specifically noted Home-Based Family Treatment as a preventative service that is unavailable due to a lack of support to develop and implement this service line. Providers acknowledge this service could provide more stability within a child or adolescent's home, but the reimbursement rate does not cover the cost of providing care, or the costs associated with training and mentoring providers to deliver in-home care.

Workforce

Providers report challenges with recruiting and retaining a qualified workforce at all levels of care as a critical barrier to building capacity across the continuum. Providers shared key insights throughout workgroup meetings, focus groups and interviews:

> *"Direct care positions should not be called entry level positions. You need a lot of skills even if not learned at school."*

> *"Level V PRTF requirements for staff are very high and hard to hire, if they were relaxed a bit, we could have more of those beds. For other positions and foster care, we have a really hard time recruiting and without these homes, children end up in higher levels of care."*

> *"It's not just about pay and training, but having the work be less stressful. Providers might stay if it wasn't so depressing and there were resources for children to go to. It makes you despondent. And, you don't get paid enough to work with the most challenging people."*

Administrative Burden and Program Start-Up

The administrative burden of community behavioral health service delivery, including documentation and service authorization requirements, contributes to inadequate workforce to meet community needs. Providers report that once clinicians are licensed, they often move to private practice where they often choose not to serve Medicaid enrollees. Additionally, community behavioral health providers have limited financial and personnel resources to plan for and start-up new programs. Providers noted the reduction in grant funding reduces their ability to be creative and fill gaps. While opening up opportunities, the 1115 Waiver also increases administrative burden for providers and limits program opportunities to what can be billed and will generate revenue.

Experiences of Children, Youth and Families in Crisis

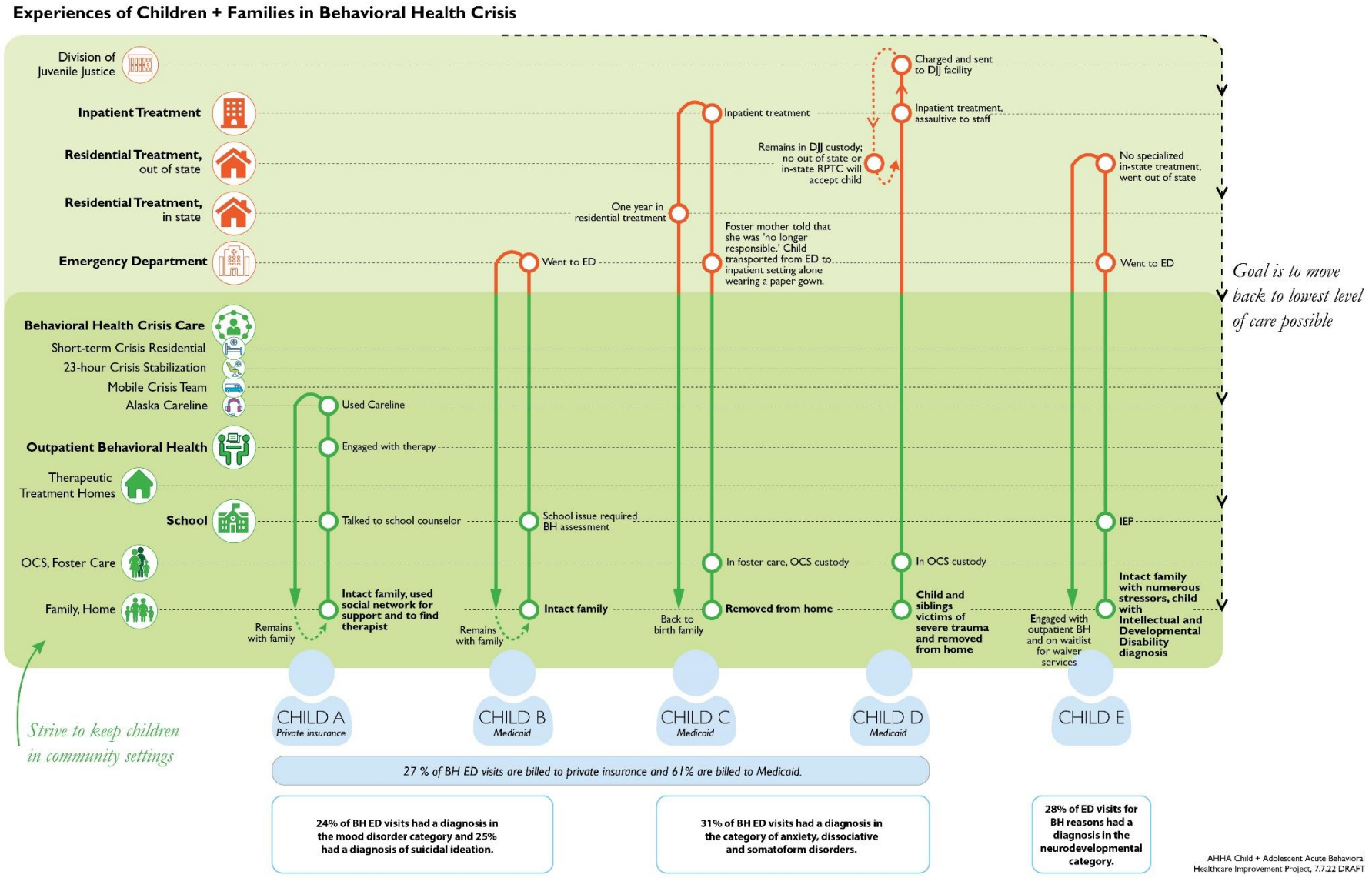
The state of the continuum for behavioral health crisis care has real impacts for children, youth, and families in crisis. Through interviews with families with lived experience and providers working with specific priority populations, a visual (Figure 24) was developed to compile case study experiences

of children and youth. The visual depicts five individuals with varying diagnoses, family supports and insurance types.

- Child A: Private insurance, intact family. Able to access outpatient therapy and psychiatric services right away when needed. Called Careline when crisis escalated but did not ever seek care in the emergency department.
- Child B: Medicaid, intact family. An issue at school necessitated further intervention. Behavioral health clinician not available at school and unable to get immediate access to an assessment in another setting so child was brought to the ED for an assessment of level of care. Child was ultimately discharged home.
- Child C: Medicaid, foster care. An issue within the foster home necessitated immediate access to care. Child did not have an established provider so was brought to the ED. At the ED, the foster mother was told she was no longer responsible for the child. The child was transported alone to an inpatient setting and did not return to the foster family where she had formed attachment.
- Child D: Medicaid, foster care. Child with severe trauma history admitted to an inpatient treatment facility. Assaulted staff, was charged and brought to a DJJ facility. While the child has significant behavioral health needs, she remains in DJJ custody as no RPTC would accept her.
- Child E: Any insurance type, intact family with numerous stressors. Child with IDD and behavioral health needs. Receives services in school for IDD needs but does not receive additional supports for behavioral health needs, and services are not coordinated for their various needs (behavioral health, physical health, IDD). Crisis resulted in ED visit and child was sent out-of-state for specialized residential treatment. Upon return home, child initiated outpatient behavioral health services and was placed on a waitlist for 1915c Home and Community-based waiver services.

The stories depicted here exemplify the challenges that children, youth, families and the providers that care for them experience every day. A robust array of services designed to meet both broad and specialized needs is not available in Alaska and access to services is often dependent on a family's ability to navigate complex systems, advocate for their child's needs, and pay for needed services.

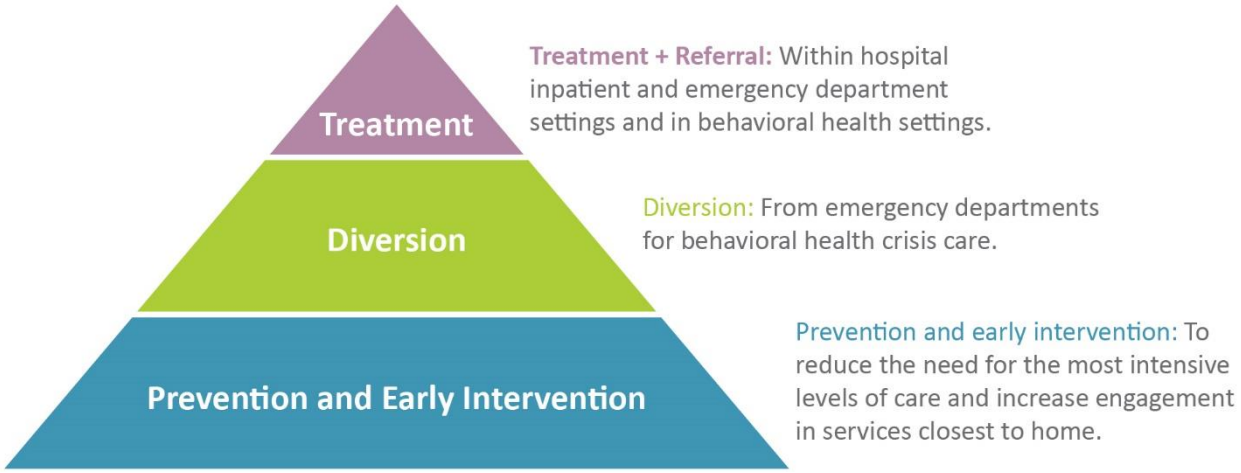
Figure 24: Experiences of children and families in BH crisis



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 25). 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 25: System Change Areas



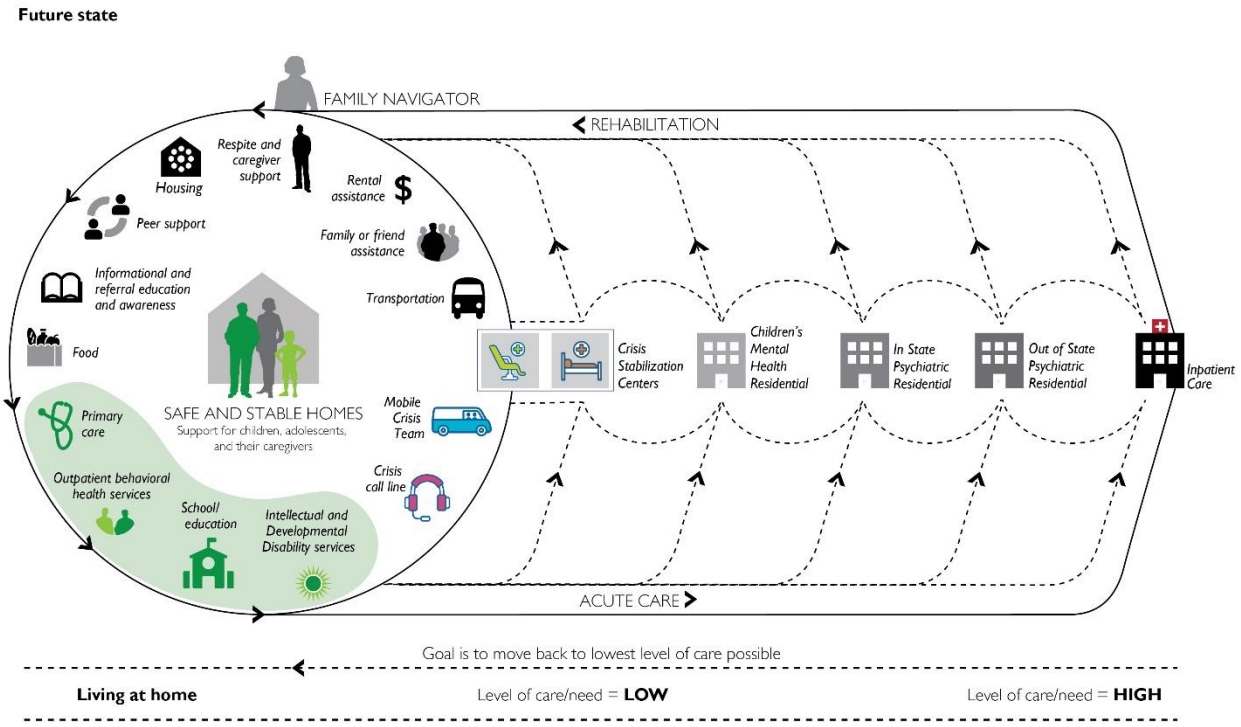
Building the Continuum

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 26) 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 26: 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 27) is organized by strategy area (numbered items) and objectives (lettered items). The top four prioritized objectives are noted in bold. The full workplan (Appendix B) 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 27. 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.[26] 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.

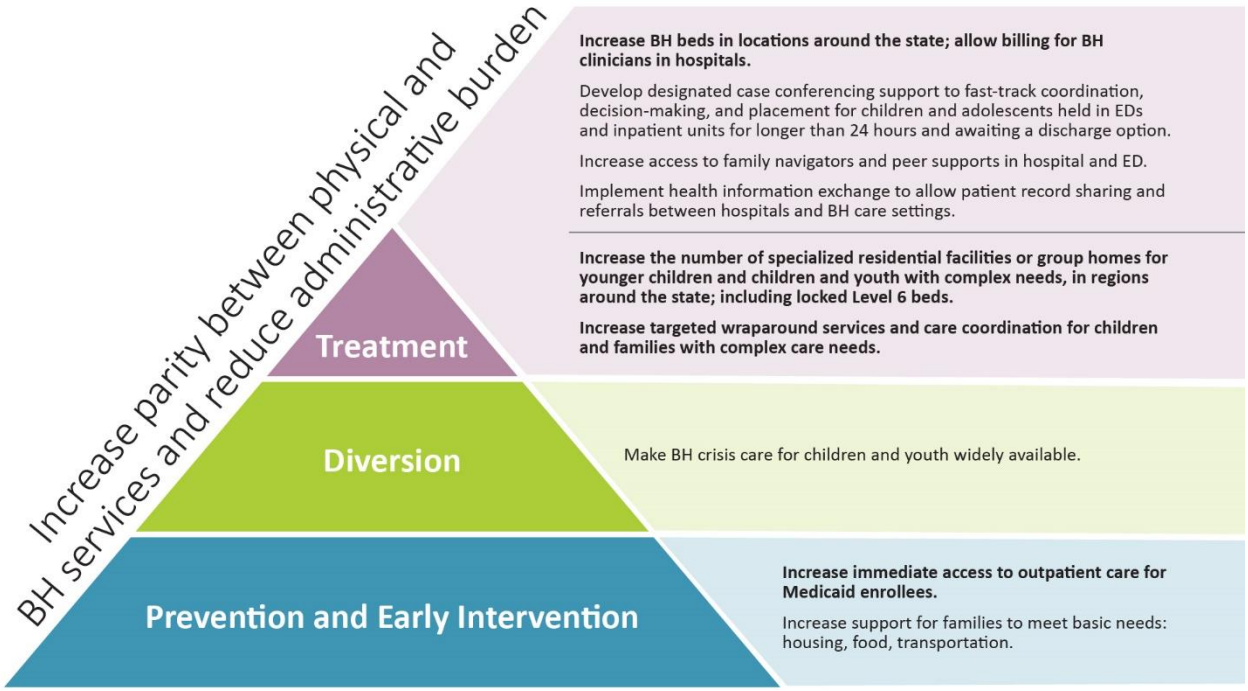
- Providers identified that the existing 1115 Medicaid Waiver services, Therapeutic Treatment Homes and Home-Based Family Treatment Levels 1, 2 and 3, lack the flexibility needed to meet families' needs. Additionally, services billed in 15-minute increments increase the provider documentation burden 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 28).

Figure 28. Prioritized Objectives for Building a Robust Continuum of Care



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Appendix A

Provider Survey, Summary Responses

A total of 29 providers responded to the survey, representing four sectors: Hospital (12 responses), Non-hospital provider (5 responses), State of Alaska (8 responses) and Other (4 responses). Survey questions were tailored to each sector.

Hospital Responses

My hospital's emergency department has the following resources:	Yes	No	Unsure
Access to psychiatric services/consults	100%	0%	0%
Designated observation rooms or beds for behavioral health patients	62.5%	37.5%	0%
Ability to initiate Medication Assisted Treatment (MAT)	50%	12.5%	37.5%
Uses brief intervention (SBIRT) protocols	50%	37.5%	12.5%
A process for post-discharge follow-up for behavioral health patients	37.5%	37.5%	25%
Psychiatric nurses	25%	75%	0%
Mental health aides	25%	75%	0%

What is working well or what best practices are you using to serve children and adolescents with behavioral health needs?

- We have Peds beds in the ER; we do not have a PEDS Psychiatrist
- We need more education/training for both nurses and providers around PED BH. We also need more education in treatment, we are partnering with the school district.
- We use age-appropriate screenings for depression and suicidality.
- Working towards cohesive transitions of care from ED to outpatient within our system. Able to board ED pediatric psych patients on the inpatient peds unit when appropriate. Have an interdisciplinary care team engaged to care for this demographic of patients.
- All patients get screened and evaluated. We work with families and OCS to make the best plan possible (which is often not the ideal plan).
- The ED has Pediatric Behavioral Health packets that are given to families to help outline care, rules, anticipated daily routine, etc. Inpatient Pediatrics has partnered with the ED to help board patients on Pediatrics that are waiting for treatment locations to open.
- We are discussing together to make things better otherwise it is not optimal currently.

What do you see as the biggest need with regard to child and adolescent behavioral health?

- Increase capacity to treat and beds for children with complex and specialized need integrate more specialties that address changing behavior IE Behavior Analysts and Occupational therapists in behavioral health
- Education training for providers, caregivers, parents. Pediatric BH protocols
- Age-appropriate resources and referral centers in the State of Alaska. Educational resources for non-psychiatric nurses providing child and adolescent behavioral health care.
- Lack of inpatient options and/or residential treatment facilities as well as lack of reimbursement for high dollar care that occurs in ED or through boarding that requires regulatory updates as well as multiple layers of safety precautions and staff.
- There are limited inpatient resources which delays the care that these patients need. Outpatient appointments are limited as well and patients wait several weeks to be seen. Placement for children and adolescents outside of a hospital is hard to find which often means patients stay in ERs. This is not the appropriate place for children/adolescence to be held and they often decompensate.
- More treatment facilities/counseling services in the state. Wait times can be extremely lengthy for children being boarded.
- Resources in the interior.

Other information that you feel is important to consider:

- Resources for places for places/prevention needed
- The behavioral health system in general is difficult to navigate and even more imposing for parents of children with needs. As a healthcare community we have an obligation to provide high quality and compassionate care to this demographic of patients that it truly seems like we are failing from the beginning.

Non-Hospital Provider Responses

What is one strategy or resource need that would help your organization serve children and youth following a behavioral health crisis?

- Additional resources for staffing crisis
- We need the ability for Telehealth Psychiatric Provided-to-Provider Consultation to be a stand-alone reimbursable service. If this exists, then training is needed on how to setup processes to support consultative services.
- More in between levels of care from inpatient/residential to community based. We need more CRC type options and even less restrictive than that to support kids and families in transitioning.

What is one service or resource your organization offers that would be beneficial for hospitals to know about (or know more about)?

- ANTHC has telehealth service to support Alaska Native/America Indian adults (18y.o.). See link for more information and ease of access for patients to self-refer. https://anthc.org/departments/behavioral-health-wellness-clinic/welcome/#

State of Alaska Responses

What projects or initiatives are you involved in that help support child and adolescent behavioral health?

- Development of an Occupational Therapist position at a DJJ facility. Discussion about complex cases short-term placement needs through the Department.
- OCS service delivery, service coordination, placement option expansion, etc.
- 1115 Behavioral Health Demonstration Waiver
- Zero Suicide, 988

Where do you see the best opportunity for improving child and adolescent behavioral health?

- Outpatient services and crisis stabilization.
- Short term sub-acute placement, assessment and stabilization.
- Ensuring step up and step-down levels of care are available across the continuum of care to reduce the need for residential and inpatient care. Additionally, the inclusion of early engagement and intervention for families is essential.
- Improved crisis system

What barriers to care or challenges in the system of care would you most like to see addressed?

- That there is no interim placement for youth besides sitting in a hospital ER for a week pending placement.
- Placement options are a critical need right now.
- Low barrier access to family services.
- Transition barriers, access to services

Other Sector Responses

Based on your experience, was there anything that stands out as a positive or something that went well?

- Better understanding and response to child and adolescent behavioral health
- Industry partnerships

What changes or issues would you most like to see addressed in the system of behavioral healthcare for children and adolescents?

- We need to have a child and adolescent behavioral health ER. Placing child and adolescents within adult populations in Psych EDs can have undesired consequences.
- Well educated and trained workforce to work with children, youth and their families in their home community.

Appendix B

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	