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Crisis Now Consultation Report

The Alaska Mental Health Trust Authority

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Trust
Alaska Mental Health Trust Authority

CRISISNOW.COM

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- Steve Williams, COO — Alaska Mental Health Trust Authority
- Sean Case, Capt. — Anchorage Police Department

Executive Summary

RI International, Inc. (RI) was awarded a contract with the Trust, on August 5, 2019. Under the Scope of Work (SOW) of that contract, RI provided consultation, assessment, analysis, and recommendations to support the conceptualization of a Crisis Now Model for adults within three Alaskan communities: the Municipality of Anchorage, the Matanuska Susitna Borough, and a third community that was yet to be identified at the time of contract execution. Fairbanks was subsequently selected as the third community.

This SOW was developed in response to the serious behavioral health demands that have continued unabated throughout these three Boroughs and the State as a whole. As of 2015, Alaska held the record for the nation's highest per capita alcohol consumption and subsequent rates of violence and abuse stemming from intoxication. Alaska's alcohol-related death rate has remained three times greater than the national average. According to the Alaska Department of Health & Social Services, the rate of alcohol-induced deaths in 2015 was 140 percent above the national average and illegal drug use was 35 percent higher. A report that it released in November 2017, indicated that meth-related deaths increased by four times over recent years and this is on top of the effects of the opioid crisis. To exacerbate matters further, Alaska's suicide rate tends to be double the national average. While these demands continue to escalate, the lack of intensive community-based prevention, intervention, and treatment services has resulted in the Department of Corrections becoming the largest provider of mental health services in the state and its EDs overburdened by psychiatric emergencies resulting in onboarding delays extending for 20 hours or more, and in some cases days.

In each of the identified communities, RI engaged in key stakeholder meetings with members of the local community/municipal/borough crisis services, including: public safety, fire and health, hospital emergency room departments (ED), substance abuse and mental health treatment providers, housing and homeless service providers and other key parties and safety net services. These meetings were facilitated by staff from the Trust, The Mat-Su Health Foundation (MSHF), and the consulting firm of Agnew::Beck. In each meeting there was a discussion around the application of the Crisis Now Model and key model standards and components. These stakeholder engagements also served as an opportunity for participants to have unanswered questions addressed and to share their respective perspectives on the Crisis Now Model and on the "goodness of fit" between this model and current community needs and resources. These discussions also served to rally support for crisis system optimization utilizing the Crisis Now Model as a guide. A crisis response system is a complex and tiered structure comprised of crisis response services that support individuals in crisis whose safety and health are threatened by challenges, including mental illness, developmental disabilities, substance use, and/or overwhelming stressors.

It was abundantly clear, within each meeting and across meetings, that there exists a broad consensus that Alaska, as a whole and the three targeted communities in particular, desperately need a comprehensive crisis response system. It was also evident that the various individuals and organizations that are in a position to respond to crises, do so out of a sense of commitment and passion for doing what is right. But ultimately, they are also frustrated and stressed by the realities associated with being inundated on a 24/7 basis by the needs of those in crisis. For too many organizations, these demands clog the service pipeline in these communities and overwhelm the capacity to meet their respective primary missions, such as public safety, healthcare, domestic violence, and shelter. What adds to this sense of being overburdened is the incidence of crises associated with violence, suicide, alcohol, meth, and opioid overdose, mental illness, and homelessness, all of which continue to escalate while service capacity has eroded over time.

Anchorage has several crisis response components of the SAMHSA Model System, such as 23-hour crisis stabilization services, urgent care/walk-in services at the Providence Psychiatric Emergency Department, and short-term crisis stabilization. The path for a Mat-Su resident to access these services requires transportation, which is not available to all individuals who are in crisis. Additionally, these services are not advertised or well known in the Mat-Su, and formal channels do not exist between these services and law enforcement, private providers, and the Mat-Su Regional Medical Center ED. The picture for Fairbanks is not much different. It possesses components of a crisis response system, but these components do not operate as a well-coordinated system either within Fairbanks or between Fairbanks and its two more densely populated neighbors – Anchorage and Mat-Su. The 24/7 crisis call center, Careline, serves all of Alaska and is located in Fairbanks.

All of the inputs for this Report have subsequently been synthesized and used to inform the application of specific algorithms in determining the capacity recommendations for each component in the Crisis Now Model that appear in the conclusion section of this Report. For each element, the report addresses cost, staffing requirements, facility size, and potential funding mechanisms, and associated system alignment issues, such as facility and provider licensing, Medicaid provider type regulations, and payment structures and rates. This Report assesses the overall cost impact of implementing its recommendations balanced against potential savings in the system. The intent is to offer a staged roadmap for how a high-fidelity Crisis Now system can be established in Alaska that is particularly responsive to the unique needs of the three service areas of Anchorage, Mat-Su, and Fairbanks.

Recommendations

Below is a summary of the recommendations of this Report. For a full explanation of the conclusions and the recommendations that flow from those conclusions, please refer to the full Report. Each recommendation within the Report has been organized within the context of the Crisis Now Model balanced against the needs and the strengths of the current BH service delivery services currently operating within the communities of Anchorage, Mat-Su, and Fairbanks. In addition, each recommendation, when appropriate, includes specific policy and operational details that outline the number of crisis facilities, programs, and services needed along with the capacity, infrastructure, and cost estimates for each.

1. Crisis System Accountability

Establish an organizational entity to be responsible and accountable statewide for the implementation, oversight, and resourcing of the Alaska BH crisis response system and to assure that this system is developed and sustained with high-fidelity to the Crisis Now Model; and likewise, determine the entities to be responsible and accountable at the regional or local level, for overseeing the various components of the crisis response system and assure that it operates as a maximally functional system.

2. Performance Expectations and Metrics

Establish performance expectations and metrics for each component of the crisis response system and the data systems to collect the information necessary to manage, analyze, and report on the performance of each component and the system as a whole.

3. Policy and Regulatory Alignment

Continue the alignment of the following elements in support of the full implementation of the *Crisis Now* Model in Alaska:

a. Statutes that will permit involuntary admissions to crisis response facilities;
b. Facility licensure standards that support all of the direct service *Crisis Now* program components,
c. 1115 Center for Medicaid Services (CMS) Waiver provisions that support Medicaid payment for services rendered by crisis facilities;
d. Medicaid administrative rules that recognize the crisis response continuum of care to include the crisis call center, MCTs, crisis facility types and the array of provider types employed therein;
e. Medicaid payment rates and types of reimbursement that make a robust crisis system in Alaska sustainable in the long term;
f. Administrative Services Organization (ASO) contract provisions that clearly articulate the role of the ASO and the Medicaid authority relative to the implementation and ongoing oversight of the crisis system; *and*
g. Policies and regulations that allow and facilitate municipalities and boroughs to actively engage in the financing, development, and implementation of the *Crisis Now Model* in their respective jurisdictions.

4. Safety Net Funding

There are still those who remain uninsured and require safety net funding in order to access crisis services. In addition, crisis call centers and MCTs are not well supported by Medicaid or other payers, whether public or profit. Therefore, it is necessary for there to be additional financial supports to sustain Alaska's adoption of and ongoing support of the *Crisis Now Model*. The State of Alaska and the respective municipalities and or boroughs included within this Report, should explore all available financing options to sustain the proposed system. Neither the Mental Health Block Grant nor the Substance Abuse Prevention and Treatment Block Grants that are distributed to Alaska from the Substance Abuse and Mental Health Services Administration (SAMHSA) are adequate to meets these needs.

5. Startup Costs

Without financial support for construction, equipment, and start-up costs associated with the establishment of new crisis stabilization facilities, it will be very challenging for providers to standup these facilities. Most providers to not have the assets necessary to assume these costs and therefore, without capital and initial operating financial assistance, these facilities will most likely not be established. Therefore, the State of Alaska, the respective municipalities and/or boroughs included within this Report, and private foundations, should partner and explore all available financing options to support the capital and initial operating costs to standup these new facilities.

6. BH Workforce Development

Alaska is already challenged by a behavioral health workforce shortage which could end up being the final major barrier to achieving the goal of implementing the *Crisis Now Model*. Therefore, the Alaska Health Workforce Coalition should adopt BH workforce development as a priority and it should be adequately resourced to accomplish this aim.

7. Rural and Frontier Crisis Service Adaptations

Alaska is a very rural and frontier state. While Anchorage, Mat-Su, and Fairbanks are fairly densely populated and, as result, can support a comprehensive crisis continuum of care. The Crisis Now Model has not been developed to meet the crisis-related challenges within rural and frontier areas. Therefore, concurrent planning needs to occur in these areas to craft local and regional crisis solutions, using the Crisis Now Model framework as a guide.

8. Peer Workforce Development

Establish a plan and implement it for Alaska to train, credential, and develop an adult Peer Support Specialist credential that is a recognized BH provider type that is authorized to deliver peer support services and is paid, or reimbursed for services rendered, within the full array of healthcare and BH treatment and support settings, particularly those associated with delivering crisis services.

9. Crisis Call Center and Mobile Crisis Teams

Establish an Alaska Crisis and Access Line that is adequately resourced to operate statewide 24/7 as a fully functional Care Traffic Control Hub that dispatches tech-enabled MCT across Anchorage, Mat-Su and Fairbanks; that possess real-time data on available crisis and psychiatric beds and outpatient BH treatment slots statewide; and provides text, chat, and peer-to-peer warm line services, also on a 24/7 basis.

10. Crisis Response Centers

Establish Crisis Response Centers in Anchorage, Mat-Su and Fairbanks that operate as high acuity levels of care under the "no wrong door" approach, admitting all those who present, whether voluntarily or involuntarily in accordance with the Crisis Now Model to include:

a. A 23-hour crisis stabilization/observation unit that uses recliners instead of beds to maximize capacity flexibility, client flow, and create an environment conducive to dialog during the initial crisis engagement period. This component acts as a "psychiatric emergency department" and accepts a large percentage of its admissions as diversions from jails and EDs.
b. A 16-bed short-term non-Institute of Mental Disease (IMD) facility with crisis beds, licensed as residential, sub-acute and/or hospital beds depending on state licensure requirements. These units are intended to serve approximately 30% of the admissions that are not stabilized in the 23-hour observation unit during the first day with an average length of stay (ALOS) between 2.5 and 3 days.

11. Cost Offsets and Reinvestment Opportunities

Once the components of Crisis Now Model are implemented, an analysis of the resulting cost-offsets should be made associated with the reductions in detention, ED, and hospital utilization; and plans developed and implemented for the reinvestment of those savings to further buildout additional enhancements to the crisis system and to the BH continuum of care to better assure that the "back door" of the crisis observation and stabilization center can remain open. This will allow for the needed client flow so that the "front door" can remain open as well, and hence always accessible. This requires providing intensive levels of community-based care, such as crisis respite, Assertive Community Treatment (ACT) teams, Multi-Systemic Treatment (MST), Functional Family Treatment (FFT) and supportive housing, supported education and employment to better address the social determinants of health.

12. Tribal Health Coordination of Care

Establish coordination of crisis care agreements with the appropriate Tribal Health entities to ensure that Alaska Native and American Indian people in need of such care, have no disruptions in continuity of care when transitioning from one service system to another.

13. Commercial Insurance Parity

The inherent inequities in the benefit structures of commercial health plans to financially support crisis care should be examined as a parity issue and addressed within Alaska's insurance regulatory structure.

14. Crisis Judicial Ruling

A judicial ruling has recently been made in a lawsuit filed a year ago by the Disability Law Center of Alaska and the Public Defender Agency seeking the cessation of lengthy jail and emergency room detentions of people in a mental health crisis. The ruling orders the Alaska Department of Health and Social Services to submit a plan for appropriate dispositions in these cases. Alaska should use the implementation of the Crisis Now Model in communities with sufficient population volumes as one of the major components of that plan.

Introduction and Background

RI International, Inc. (RI) was awarded a contract with the Trust on August 5, 2019. Under the Scope of Work of that contract, RI has provided consultation, assessment, analysis, and recommendations to support the conceptualization of behavioral health Crisis Now systems for three Alaskan communities: the Municipality of Anchorage, the Matanuska Susitna Borough, and Fairbanks.

The term "behavioral health," as defined by the Alaska Division of Behavioral Health (DBH), refers to a state of mental and emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and Substance Use Disorders (SUDs), which are often chronic in nature but that people can and do recover from. A BH crisis stabilization

service, in turn, is defined by The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) as:

> "A direct service that assists with de-escalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery."

Like a physical health crisis, a mental health crisis can be devastating for individuals, families and communities. While a crisis cannot be planned, we can plan how we structure services and organize approaches to best meet the needs of those individuals who experience a mental health crisis. Too often that experience is met with delay, detainment and even denial of service in a manner that creates undue burden on the person, law enforcement, emergency departments and justice systems.

Given the ever-expanding inclusion of the term "crisis" by entities describing service offerings that do not truly function as "no-wrong-door" safety net services, it is important to distinguish what crisis services are and what they are not. Crisis services are for everyone, everywhere and every time without undergoing a screening process. Examples of crisis level safety net services seen in communities around the country include (1) 911 accepting all calls and dispatching support based on the assessed need of the caller, (2) law enforcement, fire or ambulance dispatched to wherever the need is in the community and (3) hospital emergency departments serving everyone that comes through their doors from all referral sources.

Similarly, crisis services include (1) crisis lines accepting all calls and triaging the call based on the assessed need of the caller; (2) MCT dispatched to wherever the need is in the community (not hospital emergency departments); and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for everyone, everywhere and every time. A simple test regarding whether a service meets this standard definition of a crisis service is to inquire regarding whether there is any screening of referrals by location, acuity, eligibility or other; or any limitation of the service based on days of the week or hours of the day. If screening exists, the service may still represent an important part of a community's system of care, but the service is not representative of the *Crisis Now Model*.

There appears to be general agreement, in Alaska and nationally, that far too many persons with BH issues are arriving in hospital emergency departments, or are being charged and transported by law enforcement to detention facilities; and they are not being well served in either setting. In fact, criminal justice settings have been increasingly referred to as, "the de facto BH system." Holding those with BH conditions in EDs has been termed "psychiatric boarding" and is a growing problem most everywhere. Long waits, often for hours or even days, in often chaotic ED environments, may exacerbate symptoms and trigger trauma responses. In addition, "boarding' consumes hours of law enforcement officers' time, which they commonly refer to as, "wall time." To exacerbate this problem further, EDs typically do not have the appropriate BH personnel onboard to effectively engage and intervene when someone presents in a BH crisis.

Nationally, another unproductive dynamic revolves around BH crisis dispositions by EDs. These have become known as, "streeting." This occurs when those with presenting BH conditions are not appropriately screened and triaged and, as a result, are discharged prematurely usually without appropriate treatment and/or supports. In either case, "boarding" or "streeting" is damaging to not only those in crisis, but frequently the significant others who must endure these dynamics as well. Alaska hospitals, on the other hand, have taken substantive steps to improve the response to acute BH crisis. However, despite these best efforts, the EDs in Alaska continue to be overwhelmed by BH crises and too often have to adopt diversion status as a result. Diversion subsequently results in a kind of "musical chairs" by law enforcement, emergency medical services, and families seeking a crisis stabilization service.

From a cost standpoint, ineffective interventions in EDs or jails are poor uses of resources and they exacerbate costs because they perpetuate the crisis response "revolving door" that saps the resources of health care, law enforcement, the judiciary, incarceration settings, and social services. The ED is an expensive setting and can result in unnecessary and costly admissions for public and private insurers. Likewise are the costs associated with 911 dispatch, law enforcement, EMS, and the criminal justice system.

The underlying issues that impede the appropriate interventions for a person in a BH crisis are complex. For instance, there are many large service systems that may be involved in any given case. Each of these intervening service systems have their own respective missions, cultures, competencies, and entry points with rules for accessing services. The BH system has its own complexities and issues with having a dearth of intermediate and intensive community-based treatment options that serve people in their natural environments. It is left too often, with either having to rely on EDs and hospitals at one end of the care continuum, and routine outpatient services on the other. There are significant legal issues as well, including professional scope of practice laws, facility and service licensing (including ambulance emergency destination restrictions), and protections for those in care, including medical clearance and "certifications for involuntary admissions." Financing has its own set of challenges since insurers (public and private) have their own systems, rules, and payment rates that only reimburse certain services operated by only certain facility and provider types. And let's not forget, there are still those who are uninsured and require safety net funding in order to access crisis services. In time, the inherent inequities in the benefit structures of commercial health plans to financially support crisis care should be examined as a parity issue and addressed within the State insurance regulatory structure.

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach and this Report is intended to guide Alaska on estimating the crisis system resource needs, the number of individuals who can be served within the system, the cost of crisis services, the workforce demands of implementing crisis care, and the expected community-changing impact when services are delivered in a manner that aligns with the *Crisis Now Model*. This Report will also demonstrate how this approach harnesses data and technology, draws on the expertise of those with lived experience, and incorporates evidence-based suicide prevention practices. Perhaps the most potent element of all is human connection, which is to be authentic and to be compassionate. RI knows from experience that immediate access to help, hope and healing saves lives.

Utilizing an analysis of information collected during key stakeholder interviews, related to beneficiary utilization of emergency room care, police/fire intervention, arrest, service waitlists (such as API and/or access to other outpatient services), RI has accomplished the following:

- Identified gaps in services and opportunities for each community to include demand, optimization, costs, feasibility, and funding mechanisms;
- Identified opportunities to reduce overall health care costs, psychiatric boarding, law enforcement resources dedicated to addressing mental health crisis and incarceration of individuals when mental health treatment is the preferred intervention;
- Identified areas of overlap and opportunities for efficiency between the three communities for how to most effectively and efficiency meet the needs of beneficiaries in crisis on the front end to effectively decrease the need for higher more costly and invasive levels of intervention;
- Provided recommendations on how to align current practices with the crisis practice standard defined within Crisis Now while optimizing crisis resource design and allocations to most efficiently meet the needs of each community; and
- Held group stakeholder meetings after each regions survey to communicate initial findings back to the stakeholder groups and solicit additional feedback.

RI's crisis programs are designed to solidify a continuum of care based on the unique needs of the communities that are served. All programs incorporate the *Crisis Now* defined recovery orientation standards of (1) trauma-informed care, (2) significant use of peer staff, (3) commitment to zero suicide/suicide safer care, (4) strong commitment to safety of consumers and staff and (5) collaboration with law enforcement.

RI operates a continuum of crisis and recovery services. Included in this continuum are six Recovery Response Centers (RRC) that would be analogous to an emergency department BH challenges. RI has these facilities in Arizona, Delaware, North Carolina and Washington. RI is currently in contract negotiations to establish similar services in two additional states. A Recovery Response Center operates as a TRUE crisis receiving facility that accepts all referrals based on the *Crisis Now* exceptional practice standards model. A RRC has two distinctive program components. The first component is a 23-hour crisis stabilization unit that accepts both voluntary and involuntary patients. These programs use recliners instead of beds to maximize capacity flexibility and create an environment conducive to dialog during the initial crisis engagement period. This component acts as a "psychiatric emergency department" and accepts and triages a large percentage of its admissions as diversions from jails and EDs. In RI's 36-recliner facility in Peoria Arizona, 82% of the approximate 5,000 admissions arrived from the back of a police car in 2018.

The second component is a 16-bed short-term non-IMD facility, usually attached, with crisis beds licensed as residential, sub-acute or hospital beds depending on state licensure requirements. These units serve the approximately 30% of the population that are not stabilized in the 23-hour observation unit during the first day, with an average length of stay between 2.5 and 3 days. These units were identified by the Crisis Services Task Force of the National Action Alliance for Suicide Prevention as a nationwide best practice and were included in the *Crisis Now* monogram. The second concept is that a person thrives when able to access community services. As a result, true crisis programs look toward resolving the crisis as quickly as possible with a focus on supporting their return to the community for additional support. This is demonstrated in a low average length of stay for all exemplar level crisis service programs. This strongly drives efforts at "warm hand-offs" to outpatient BH and other community-based programs.

RI's philosophy meets people where they are. It allows enhanced opportunity for recovery and connection. This decreases ED utilization, hospital admissions, readmission, and criminal detention while enhancing individual satisfaction. And it's the right thing to do. RI is a strong believer in the power of employment to advance an individual's path to recovery. RI fully appreciates this potential since over 50% of our workforce

is advancing in their own recovery; modeling the positive impact of engaging in meaningful employment as part of a recovery journey. We also understand that adequate income is essential to creating self-sufficiency, pursuing one's goals and meeting basic needs that are the foundation to sustained recovery.

The keystone to any crisis response system is a 24/7 crisis call center which dispatches MCTs. A crisis call center operating with fidelity to the Crisis Now Model employs Care Traffic Control technology developed and employed by Behavioral Health Link (BHL) in Georgia, a strategic partner of RI. More about the role of these two components is delineated in the following Crisis Now Model section of this report. It is important to emphasize, that roughly 90% of crisis calls can be appropriately resolved by the call center and another 70% resolved "on the ground" by MCTs.

The Crisis Now Model

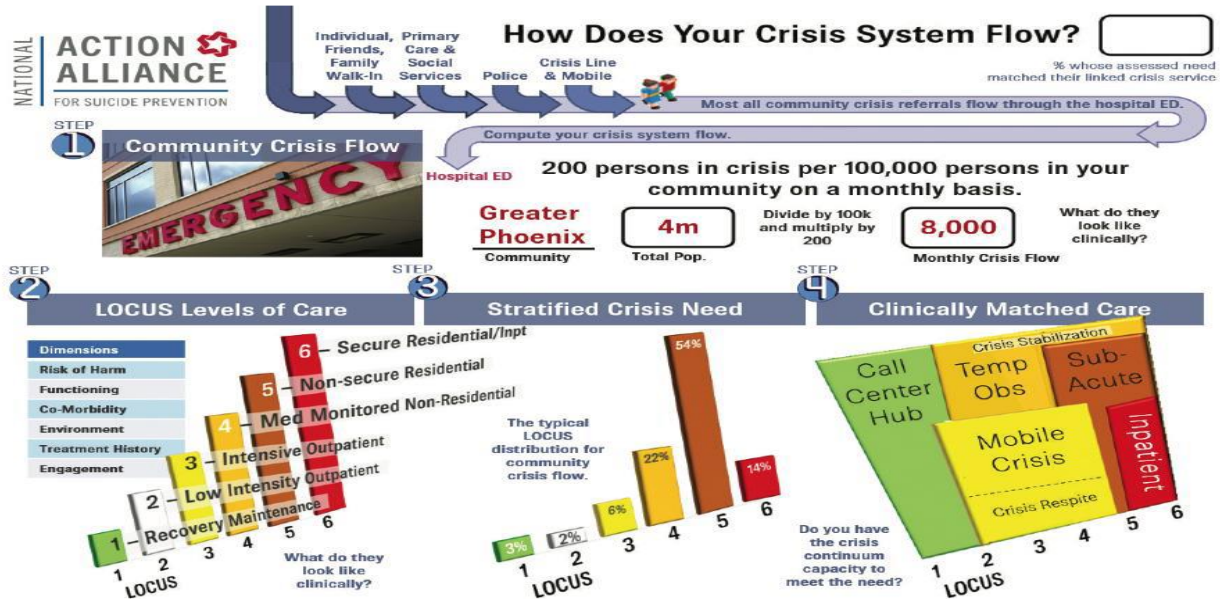
According to the paper published by the National Association of State Mental Program Directors (NASMHPD) and co-authored by RI's CEO, David W. Covington, LPC, MBA, *Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness*, August 2018, individuals in crisis often interface with the justice system, first responders, hospital emergency departments and correctional facilities. These resources are essential to supporting a healthy community, but they are not designed to meet the unique needs of individuals experiencing a BH crisis.

The diagram on the following page represents potential paths of flow for individuals experiencing a BH crisis. It is estimated that for every 100,000 members of a representative population, 200 of those population members will experience a crisis that requires something more than a typical outpatient or phone intervention. Research has enabled the utilization of data to stratify the service level needs of those individuals; and that data can be applied to most efficiently design a cost-effective service delivery system.

Timely access to vital acute psychiatric inpatient (hospital) care is frequently unavailable for individuals experiencing the most significant behavioral health crises. A decade of Level of Care Utilization System (LOCUS) assessment data gathered in Georgia by MCTs, emergency departments and crisis facilities indicates (see the National Action Alliance for Suicide Prevention's diagram below) that 14% of individuals experiencing a crisis who have reached these higher levels of care have a clinical need that aligns with inpatient care (LOCUS level 6). A majority (54%) of these individuals experiencing a mental health crisis have needs that align better with services delivered within a crisis facility and 32% have lower level needs that would benefit from assessment by a mobile team (LOCUS levels 1-4). It is important to note that this LOCUS data set does not include an assessment of individuals who only contacted the crisis line. Therefore, it is used to only stratify the clinical needs of those engaged by higher levels of care and is not being used to predict crisis line resource needs.

As indicated above, it is expected that 200 individuals per 100,000 will experience a crisis that requires a service level more acute than can be accommodated by outpatient services or a phone intervention. If this ratio is applied to Alaska with a population in 2019 of 710,231, it would be expected that over 1,400 individuals would annually be in need of more intense crisis services. If 54% of these are expected to require admission to a crisis facility, the number of admissions would be 756. Similarly if 32% require a MCT intervention, that annual number is 448. The numbers requiring acute inpatient psychiatric care

would be 196. While this formula has been applied to states and localities throughout the U.S., it appears to be too conservative when applied to Alaska. For example, the Careline, which serves as Alaska's statewide suicide intervention crisis line, is now receiving over 20,000 crisis calls annually and it has indicated that roughly 10% of these would qualify for a MCT dispatch, which is 2,000. This is a significantly greater number than 1,400.



The key elements of a comprehensive behavioral health crisis system are:

1. **Regional or Statewide Crisis Call Centers**. The "front door" of a modern crisis system is a crisis call center that meets National Suicide Prevention Line (NSPL) standards and participates in the national network. Since 2005, SAMHSA has funded multiple research projects to evaluate the critical role of crisis call centers as indispensable resources for suicide prevention. Nationally more than 160 call centers meet the standards of and participate in the NSPL. Such a crisis call center is equipped to efficiently connect individuals in a BH crisis to needed care. These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems every minute of every day. That real-time care coordination requires electronic linkage with every BH inpatient, and residential bed and with every outpatient treatment slot in the service area. At the same time, they provide high-touch support to individuals and families in crisis that adheres to National Suicide Prevention Lifeline (NSPL) standards. In order for Call Centers to be accessible to youth, it is critical that they include the technology and the staffing to support both texting and chat capabilities. The Crisis Call function can be further supplemented by a Peer to Peer Warm Line that is staffed by Certified Peer Support Specialists. This service can provide 24/7 readily accessible support, outreach, and postvention which can prevent the emergence of future crises or re-stabilize an individual who is beginning to feel over-stressed, overcome with drug cravings, or feelings of loneliness, hopelessness, and burdensomeness.

2. **Centrally Deployed Mobile Crisis Teams on a 24/7 Basis**. Mobile crisis services are typically comprised of a two-person (licensed clinician and peer partnerships are common) mobile crisis team that offers assessment, outreach, and support where people in crisis are; either in the person's home or a location in the community (not a healthcare facility). The two person model is intended to assure greater safety for the teams in their work in the community, to ensure that those served have the best opportunity for engagement, and to allow for the transportation of those served when warranted, eliminating the need for overuse of the police and ambulances for transportation. Recently, programs have shown greater success by using GPS-enabled technology dispatched from the crisis call center to efficiently connect individuals in crisis with the nearest available mobile team. Programs should include contractually required response times and medical backup. The MCT provides a timely face-to-face response and requires the capacity to intervene quickly, day or night, wherever the crisis occurs. In cases where the person in crisis cannot be stabilized and kept into the community, the MCT assists in transferring care to a higher level program and will provide transportation for those that are voluntary when it is safe to do so.

3. **Crisis Observation and Stabilization Facilities**. These facility-based programs offer short-term BH crisis care for individuals who need support and observation. Design of these facility-based programs may vary, but ideally they will include a medically staffed flexible observation/stabilization area with recliners, instead of beds, (often limited to less than 24 hours of care) and that implements a "a no wrong door" process in which walk-ins, law enforcement and other first responder referrals are immediately accepted without requiring any form of screening prior to acceptance. This includes both voluntary and involuntary admissions and therefore, must be staffed and equipped to assure the health and safety of everyone within the facility. These units are typically a high speed assessment, observation, engagement, and stabilization service. Each admission receives the following services: a psychiatric evaluation by a Licensed Psychiatrist or Psychiatric Nurse Practitioner that includes a risk assessment and medication evaluation; a brief medical screening by a registered nurse to ensure that co-occurring medical issues are addressed; Substance Use Disorder screening and assessment by a licensed clinician; a psychosocial assessment by a licensed clinician; crisis stabilization services utilizing a high engagement environment with a strong recovery focus and peer support model; comprehensive discharge planning and community coordination of services.

   These observation stabilization programs are typically paired with some form of subacute short-term (2-5 day) facility-based crisis program (either inpatient, respite or residential) to offer more than 24 hours of care without escalating to more costly acute inpatient options that would result in longer lengths of stay and higher per diem costs than programs with specific behavioral health crisis resolution expertise. This program needs to be licensed to accept involuntary guests and have the licensed ability to offer seclusion and restraint services, if needed. This unit is intended to serve approximately 30% of the population that were not sufficiently stabilized during the 23-hour observation unit stay.

   Both settings should be designed as inviting non-institutional environments that are enhanced by natural light and hopeful and inspiring aesthetic features. Common security elements such as uniformed and armed security guards and razor wire fences are anathema to this model. Program interventions are delivered by both professional (MD, PNP, RN, Clinician) and paraprofessional

(certified peer support specialists) staffs designed to support ongoing recovery utilizing a combination of treatment models, including comprehensive discharge planning and community coordination of services. But equally important is this interdisciplinary team creates and sustains an environmental milieu where all "guests" are treated with dignity and respect, are authentically and meaningfully engaged, and when dysregulated are allowed the space, time, and support necessary to de-escalate. As a result, these stabilization settings, when appropriately staffed, are able to assure greater safety than normally expected in crisis settings. Seclusion and restraints are available, but rarely applied.

It should be noted that once these core Crisis Now Model components are in place and operating as intended, there are additional crisis systems service enhancements that can be made. These can include a Peer Navigator service that assists individuals who have accessed crisis services to subsequently navigate health and human services systems in order to access the benefits and services that potentially further stabilize and improve one's quality of life, such as permanent supportive housing, supported employment or education. Another option is a Crisis Respite Center that is managed by and staffed with Peer Support Specialists. Crisis Respite is typically a short term (two week) residential environment that operates as a transition from crisis stabilization to the community, or as a step up from the community to prevent a potential crisis. Other alternative models are being developed as communities become freer to innovate in meeting identified needs and garner a broader base of practice-based evidence.

Communities that lack a crisis service continuum pay the price in terms of the cost of law enforcement engagement in addressing BH crises, the expense of incarceration, the negative impact on the quality of life for individuals in the community, and ED and hospitalization costs. Those unable to access needed services in a timely manner endure the effects of psychiatric boarding (waiting in an ED for hours or days) and the exacerbation of symptoms and distress. For payers of healthcare, a lack of adequate crisis resources translates into paying unnecessary ED bills that are estimated to typically cost between $1,200 and $2,260. In contrast, 96% of individuals directly referred to a crisis provider do not require an ED visit. Additionally, acute psychiatric inpatient care often comes with a higher per diem rate and a longer average length of stay than crisis facilities. The escalated expenses increase healthcare costs by an estimated 100% of the costs realized within a comprehensive crisis system.

The desired model is to connect individuals to a crisis provider as quickly as possible using a systemic method that is analogous to the healthcare delivery system's approach to medical emergencies. The table below demonstrates how Crisis Now service elements align with the crisis services components operating within most communities. This prototype can also be used as a tool to help model reimbursement for these similar services in a manner consistent with parity expectations.

Responding to a Medical Crisis vs. a BH Crisis			
	Medical System	**BH Crisis System**	**Crisis Now Model**
Call Center	911	Crisis Line or 911	Crisis Line
Community Service	Ambulance / Fire	Police	Mobile Team
Facility Option	Emergency Dept.	Emergency Dept.	Acute Crisis Observation & Stabilization Facility
Facility Response	Always Yes	Wait for Assessment	Always Yes
Escalation Option	Specialty Unit (PRN)	Inpatient if Accepted	Crisis Facility or Acute (PRN)

The *Crisis Now Transforming Crisis Services: Business Case* suggests that a comprehensive crisis system is affordable and within reach of most communities. The cost of crisis services can be covered by the reinvestment of savings from the decreased spend on hospital-based services and incarceration. In Maricopa County, Arizona, which includes the greater Phoenix area, the associated savings of a crisis system containing all three core aspects of a crisis system have included the following system efficiencies:

- 37 full-time equivalent (FTE) police officers engaged in public safety instead of behavioral health transportation/security;
- Reduction in psychiatric boarding time of 45 years annually; and
- Decrease in inpatient hospitalization spend by $260 million.

The escalating costs communities pay for not investing in a comprehensive crisis system are unsustainable; manifesting as demands on law enforcement, other first responders, justice systems, emergency departments, service providers of all types, and public and private payers. These escalating demands in our communities are pushing the limits of what is affordable and sustainable, while resulting in adverse outcomes for those in need of care and the communities within which they reside. The impact to vulnerable members of our communities, and their families are devastating. A comprehensive crisis system that includes the three core components is essential to all communities. Zero unnecessary admits for behavioral health conditions to emergency departments and zero unnecessary bookings into jail are attainable goals through the implementation of the *Crisis Now Model*.

To learn about the Core Principles and Practices of *Crisis Now*, please refer to Appendix A of this Report.

Methodology

The over-arching goal of this project was to determine how to align current crisis practices within each of the respective communities to the practice standard for BH crises defined within the *Crisis Now Model*, while also optimizing crisis resource design and allocations to most efficiently meet the needs of these

respective communities; and to find opportunities to reduce overall health care costs, psychiatric boarding, law enforcement resources dedicated to these crises, and the incarceration of individuals when behavioral health treatment is the preferred intervention. In order to implement and sustain comprehensive BH crisis systems that are in fidelity to the *Crisis Now Model*, RI examined available information regarding Alaska's alignment of facility licensure standards, CMS 1115 BH Waiver provisions, Medicaid administrative rules regarding recognized provider types and services, along with payment rates, and plans for the implementation of a behavioral health Administrative Service Organization.

Lastly, RI applied the pertinent data that was gleaned throughout the assessment process, to its algorithmic formulations to determine the general crisis capacity needs for each of the three communities. The results of these calculations were subsequently modified to accommodate the unique permutations of population and health-seeking flows within and between these communities and Alaska as a whole. The results were then analyzed against current crisis service assets and strengths to develop a set of concrete recommendations on how to best develop and implement a staged approach to achieving the Crisis Now Model within the three respective communities in a way that will also have overflow benefits to Alaska as a whole. RI implemented the following methodology and management plan to accomplish the scope of services in meeting the Trust's objectives for this project.

- **Pre-Planning:** Tele-conferences were convened with the Trust to discuss the project schedule, deliverables and review pre-visit questions initially for the communities of Anchorage and Mat-Su; and later for Fairbanks.
- **Assessment:** RI initially gathered information on the existing crisis systems in Anchorage and Mat-Su, and later on Fairbanks, which included an examination of substantiated needs, an inventory of existing crisis services, and an analysis of the gaps in the crisis services provided within these three communities. This was completed through a review of existing publicly available records and data. Each of these sources is listed in the Reference Appendix of this Report. Additionally, RI's consultant team conducted stakeholder interviews over the course of almost three weeks. At the closure of a week of interviews within each locality, interviewed organizations were invited to be represented at a high level closing debriefing session regarding the week of interviews. These forums provided an opportunity for attendees to not only question the RI consultant team, but also leadership from the Trust and DBH. In the case of Mat-Su, the MSHF leadership was at the table and in Fairbanks, the Trust again was present.

  The following organizations participated in the interviews and debriefings with each community:

  - Abused Women's Aid In Crisis, Inc. (AWAIC)
  - Akeela, Inc.
  - Alaska Court System, Wellness Court
  - Alaska Department of Corrections (DOC)
  - Alaska Department of Health and Social Services (DHSS) and Division of Behavioral Health
  - Alaska Family Services
  - Alaska Mental Health Trust Authority (the Trust)
  - Alaska Native Medical Center (ANMC)
  - Alaska Native Tribal Health Consortium

- Alaska Psychiatric Institute (API)
- Alaska Regional Hospital
- Alaska State Hospital and Nursing Home Association (ASHNHA)
- Alaska State Troopers, Palmer and Fairbanks Posts
- Alaska Youth and Family Network
- Anchorage Airport Police Department
- Anchorage Coalition to End Homelessness
- Anchorage Community Mental Health Services, Inc. (ACMHS)
- Anchorage Fire Department
- Anchorage Neighborhood Health Center
- Anchorage Police Department (APD)
- Bean's Café
- Catholic Social Services
- Careline
- CHOICES
- City of Wasilla, Mat-Com Dispatch
- Connect Mat-Su
- Cook Inlet Tribal Council
- Covenant House
- Fairbanks Airport Police Department
- Fairbanks Community Mental Health Services
- Fairbanks Fire Department
- Fairbanks Memorial Hospital
- Fairbanks Native Association
- Fairbanks Police Department and 911 Dispatch
- Fairbanks Reentry Coalition
- Fairbanks Rescue Mission
- Fairbanks Youth Council
- Family Centered Services of Alaska
- High Utilizer Mat-Su (HUMS) Program
- Mat-Su Borough Emergency Services
- Mat-Su Crisis Intervention Team Coalition and other local providers
- Mat-Su Emergency Medical Services
- Mat-Su Health Foundation (MSHF)
- Mat-Su Health Services
- Mat-Su Regional Medical Center (MSRMC)
- Mat-Su Pretrial
- Mat-Su Wellness Court
- Municipality of Anchorage
- My House
- NAMI Anchorage and Alaska
- Palmer Police Department
- Providence Health and Services
- Rasmuson Foundation
- Restore, Inc.

- Set Free Alaska, Inc.
- Southcentral Foundation
- Tanana Chief's Conference
- Turning Point Counseling Services
- True North Recovery Services, Inc.
- University of Alaska Anchorage Police Department
- University of Alaska – Fairbanks, Fire Department
- Volunteers of America (Anchorage)

- **Analysis and Draft Report, and Implementation Plan Development:** RI analyzed the assessment results to identify gaps and opportunities for each of the three communities. This was followed by an analysis of service demand, crisis system optimization, costs, feasibility, and a review of funding mechanisms and weighed against potential areas of duplication that might present an opportunity for efficiency between the Anchorage, Mat-Su, and Fairbanks service areas. Subsequently, RI developed an implementation plan, balancing all of these elements and reviewed it with the Trust, DBH, and MSHF.

- **Community Engagement:** RI engaged current and potential future stakeholders to rally support for crisis system optimization utilizing the Crisis Now framework. Large community in-person forums for stakeholders were convened in Anchorage, Mat-Su, and Fairbanks to begin to build consensus within the community. Invitees for this forum were determined by working with the Trust, DBH, and MSHF.

- **Final Report and Plan:** This Report is the project's final work product which is intended to be a roadmap for the development and implementation of Crisis Now Model services in Anchorage, Mat-Su, and Fairbanks that build on the current crisis assets within each service area while maximizing system efficiencies whenever possible. This Report contains all of the substantive information acquired in the course of the project and will be able to be publicly shared by the Trust, MSHF, DBH, and others. This Report includes:
  - An overview of project, lessons learned, and recommendations for the future;
  - A brief description for each of the communities of specific elements of the crisis system (call center, mobile teams, crisis stabilization/crisis residential, staffing characteristics, recovery values) with recommendations for needed capacity.
  - A recommended plan for each community (within the context of the needs of Alaska as a whole) as to how to best incorporate existing community resources, and which elements should be enhanced/created. For each element, this Report addresses cost, staffing requirements, facility size, and potential funding mechanisms. This Report also assesses overall cost impact of the implementation of recommendations balanced with potential savings to the system.
- **Wrap-Up Meeting:** The goal of this meeting was to review initial findings, answer questions and determine actionable next steps. This involved a collaborative teleconference meeting between representatives from the Trust, DBH, MSHF, and RI's consultant team.

Findings and Analyses

Alaska and its various service entities have done a commendable job over time of chronicling BH needs locally and statewide, inventorying related existing service capacity, completing gaps analyses, issuing recommendations for providing a more comprehensive response to not only BH-related needs, but also their social determinants. This body of work has included analyses and recommendations related to needed public policy changes and rate structures to support a wide array of recommended service system enhancements. The following reports were reviewed in preparation of this Report and the relevant information gleaned from their respective findings and recommendations for assessing the crisis response systems in Anchorage, Mat-Su, and Alaska, have been integrated herein:

- *Alaska Behavioral Health Systems Assessment Final Report*, prepared by Agnew::Beck Consulting, LLC and Hornby Zeller Associates, Inc., Updated January 22, 2016.
- *Alaska State Hospital and Nursing Home Association's (ASHNHA) Acute Behavioral Health Care Improvement Project - Civil,* prepared by Agnew::Beck Consulting, LLC, 2019.
- Anchorage Fire Department Mobile Integrated Health Program: Community Para-medicine White Paper, 2018.
- *Division of Behavioral Health's Forensic Psychiatric Hospital Feasibility Study – Forensic*, prepared by Agnew::Beck Consulting, LLC, 2019.
- *Fairbanks North Star Borough Behavioral Health Services Assessment: A Local Perspective*, Fairbanks Wellness Coalition, prepared by GOLDSTREAM Group, Inc., 2018.
- *HEALTHY FAIRBANKS 2020 Community Health Needs Assessment*, Final Report, 2015.
- *Mat-Su Behavioral Health Environmental Scan: Report 1 – The Crisis Response System*, prepared by the McDowell Group and the Western Interstate Commission on Higher Education (WICHE), 2014.
- *Mat-Su Behavioral Health Environmental Scan: Report 2 – The System of Care*, prepared by the Mat-Su Health Foundation and the Western Interstate Commission on Higher Education (WICHE), 2015.
- *Mat-Su Regional Medical Center Emergency Department Data Analysis Partial Preliminary Draft Report*, prepared by the McDowell Group, 2017.
- *Strengthening the System: Alaska's Comprehensive Integrated Mental Health Program Plan* 2020-2024, Alaska Mental Health Trust Authority, 2019.

The very first opportunity identified in the *Alaska Behavioral Health Systems Assessment Final Report* that was updated in 2016 was, "Statewide gaps in the continuum of care combined with gaps in health care coverage perpetuate a cycle of crisis response and create costly inefficiencies." ASHNHA's 2019 report on *Acute Behavioral Health Care Improvement Project –Civil* further validated this finding and concluded,

> "Alaska is not effectively stabilizing and treating psychiatric patients, and does not have capacity for long term treatment or effective discharge to community services."

The recommendations coming out of that report centered on a more traditional approach to strengthen Alaska's current continuum of acute BH services particularly in EDs and hospitals. It focused on

improvements in emergency departments, hospitals, and community-based services to better serve those with BH conditions.

A key finding from *DBH's 2019 Forensic Psychiatric Hospital Feasibility Study* was,

> "Alaska needs to divert more people experiencing mental illness and psychiatric crisis from the criminal justice system to appropriate behavioral health programs, and address basic needs."

A key recommendation from that report was to, "Implement a *Crisis Now* crisis stabilization model." To accomplish this, it was further recommended that DBH and the Trust execute "a technical assistance contract with RI International to provide recommendations on development of crisis stabilization in Alaska." This Report represents the initiation of that technical assistance.

The one exception to the consensus view that a crisis continuum of services is critically needed in Alaska was reported in the 2018 *Fairbanks North Star Borough Behavioral Health Services Assessment: A Local Perspective*. In a survey of clients, providers, organizational leadership, and community support organizations, crisis or emergency services were reported to be "the easiest services to obtain. This response was among the three highest scoring services for two of the four groups of survey takers (providers and community support organizations). We can only surmise that respondents were framing their answers relative to the responsiveness of EMS and police response. Given that inpatient mental health services and detoxification for drugs other than alcohol, were the two most difficult services to access according to three of the four groups surveyed, the implementation of the Crisis Now Model in Fairbanks would address the barriers associated with access to both services. Because of problems faced by the Alaska Psychiatric Institute (API) in Anchorage, Fairbanks' already bad situation with managing BH crises has been deemed as getting worse.

API has faced federal and state scrutiny, at one point almost losing its ability to participate in Medicaid. Because of multiple challenges, including significant staffing shortages, over half of the 80 beds at the facility have at times been out of commission. As a result, patients from Anchorage have been sent to Fairbanks and Juneau to receive care. As Fairbanks began to experience the back-flow of patients out of Anchorage and the Mat-Su, Fairbanks has been struggling to meet its own community BH needs.

The need for a crisis response system was echoed in the multiple interviews that we participated in each of the three communities. When asking questions about the crisis response system within each locality, it was not uncommon to hear something like, "What crisis response system?" or "We do not have a crisis system!" Others were more nuanced in their replies and could identify components of the crisis response system, but even these communications were colored by the inadequacies experienced at differing levels within each locality. Without doubt, there is a seemingly universal perspective shared by those we spoke to, that a responsive crisis system is desperately needed, not only in their communities, but statewide. In addition, it was evident that all BH-related service providers, including law enforcement, EMS, and the judiciary, were all over-burdened and frustrated by this reality.

Many participants shared, that in an attempt to manage day-to-day crises, their respective organizational resources are being over-taxed and they are personally feeling overwhelmed by these day-to-day, on-the-ground, realities. When discussing the merits of the *Crisis Now Model*, one Police Chief expressed his frustration by stating, "We have been talking about this for over five years, when are we going to do it?" Bottom line is that these service system inadequacies are having a deleterious impact on those that need them and on those who are connected to them. The irony in all of this, is that the vigorous attempts, in each community to stabilize BH crises, is expensive and ineffective for the most part. These dynamics are occurring in environments where resources are definitely limited, if not scarce. As a result, it is incumbent on all stakeholders to utilize every resource as effectively and efficiently as possible. This will require collaboration to change the crisis response status quo from, "the wrong service, at the wrong time, and at the wrong place," to "the right service, at the right time, and at the right place."

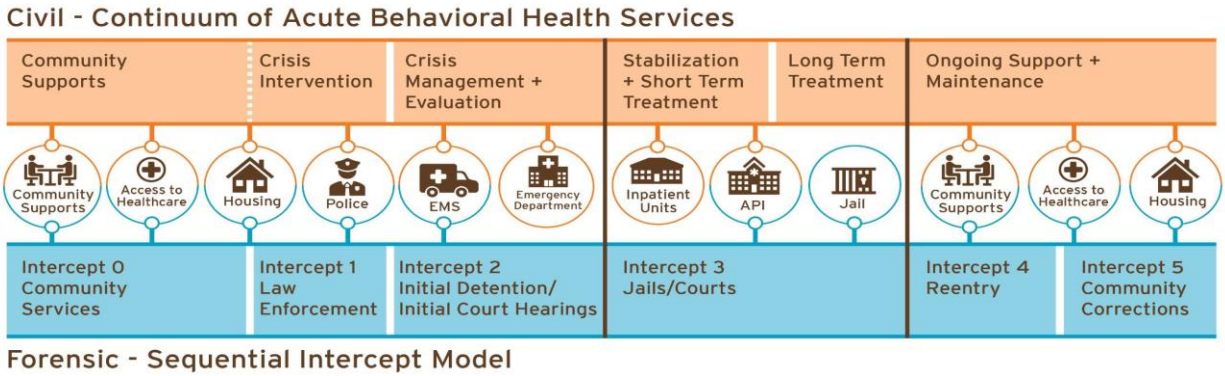
In preparing the recommendations for this Report, the RI consultant team became firmly convinced that the *Crisis Now Model* holds tremendous promise for Alaska, and in particular, for the higher density populated communities of Anchorage, Mat-Su, and Fairbanks. Implementation of the *Crisis Now Model* has the potential of meeting the BH crisis-related recommendations from the reports cited above. This perhaps can best be illustrated by the diagram entitled, "*Civil + Forensic Psychiatric Continuums of Care*," that Agnew::Beck Consulting developed to illustrate the BH continuum of care in conjunction with the Forensic Sequential Intercept Model. The application of the *Crisis Now Model* provides for a set of community-based BH crisis intervention and stabilization facilities and services that effectively and efficiently meet the community needs associated with Intercept Levels 1, 2, and much of 3.

Once established, the component services of *Crisis Now* will divert the overwhelming majority of individuals experiencing BH crises from EDs and jails. It is the best conceivable solution for both the civil and forensic sides of the BH crisis equation. The re-engineering recommendations for EDs and hospitals forwarded by Agnew::Beck, to better accommodate the needs of those with BH conditions, should in large measure still be carried out. But significant modifications of those recommendations are warranted on the civil side with the implementation of the *Crisis Now Model*.

Fully implementing *Crisis Now* however is not without its challenges and those challenges will be delineated later in this Report. But there is another dimension associated with BH crises that *Crisis Now* will also ameliorate. A judicial ruling has recently been made in a lawsuit filed a year ago by the Disability Law Center of Alaska and the Public Defender Agency seeking the cessation of lengthy jail and emergency room detentions of people in a mental health crisis. This problem appears to be exacerbated by the shortage of bed availability at the Alaska Psychiatric Institute. The ruling orders the Alaska Department of Health and Social Services to come up with a plan for appropriate dispositions in these cases. The Disability Law Center stipulates that the State will have to meet three conditions to comply with the plan:

- Eliminate the practice of taking people to DOC when other facilities can't admit them;
- Provide evaluations, potentially in emergency rooms, to see if a person no longer meets the legal criteria to be held, or could go to another facility for anyone stuck awaiting a room at API; and
- Make sure people in jail whose charges are dismissed, but meet criteria for civil commitment move to a psychiatric facility within 24 hours.

RI has collaboratively worked with other states that have faced similar issues with expeditious and clinically appropriate dispositions for civil commitment. Some years ago, Alaska implemented two Designated Evaluation and Treatment (DET) Programs for this purpose located in Fairbanks and Juneau. It is somewhat outside the scope of this Report, but it would seem worthwhile to fully assess the functioning of both DETs and determine if the DET model is meeting today's needs and whether it requires re-design; or as *Crisis Now* is being implemented, will DETs no longer be necessary? If this proves to be the case, the expense associated with the operation of DETs could be reinvested to support either *Crisis Now* implementation or to further buildout intensive community-based treatments and supports.



Agnew::Beck Consulting 2019

Each of the reports reviewed have built the case using incidence, prevalence, utilization, and other data to substantiate the critical need for the application of the *Crisis Now Model* in Alaska. Because of this rich archival of documented data, RI will not be replicating what already has been thoroughly documented. Instead, it should suffice to conclude, as represented as a strategy in *Alaska's Comprehensive Integrated Mental Health Program Plan 2020-2024,* "Ensure crisis stabilization services statewide."

One of the documents reviewed was the *Mat-Su Behavioral Health Environmental Scan: Report 1 – The Crisis Response System* prepared by the McDowell Group, the Western Interstate Commission on Higher Education (WICHE) and the Mat-Su Health Foundation in November, 2014, which used the Substance Abuse and Mental Health Services Administration's (SAMHSA) Good and Modern Addictions and Mental Health Services System typology for its recommendations for a crisis response system in the Mat-Su Borough. This is an applicable framework for examining the crisis response capacities of the Municipalities of Anchorage and Fairbanks as well. Please refer to the Table that follows.

Modern Addictions & Mental Health Services System	Crisis Response Services Capacity by Community		
	Mat-Su	**Anchorage**	**Fairbanks**
Warm line	Careline	Careline	Careline
Medically monitored intensive inpatient	-	Southcentral Foundation Detox	Fairbanks Native Association (FNA) Detox

Peer-based crisis services	True North Recovery Cook Inlet Tribal Council	-	-
23-hour crisis stabilization service	-	Providence Psychiatric Emergency Room (PPER)	-
24/7 crisis hot-line services	Careline Mat-Su Health Services (MSHS)	AWAIC Careline PPER Anchorage Community Mental Health Services (ACMHS)	Careline Fairbanks Community Behavioral Health Center (FCBHC)
Urgent care/walk-in services	MSHS Matsu Regional BH - ED	PPER	Fairbanks Memorial Hospital (FMH) -ED
Mobile crisis services	-	Anchorage Safety Patrol (ASP) Crisis Intervention Team (CIT) CRT (APD) Anchorage Fire Dept. CORE Team (AFD)	Crisis Intervention Team (CIT)
Short-term crisis residential/stabilization	-	Alaska Native Medical Center (ANMC) Alaska Regional Alaska Psychiatric Institute (API) AWAIC Providence Crisis Recovery Center (PCRC) Safety Center	FMH – BH Unit

The dash Indicates that the services does not exist

The original Table 5. in Report 1 of the *Mat-Su Environmental Scan* only compared these services for the communities of Mat-Su and Anchorage. Fairbanks was added for the purposes of this Report. Report 1 states:

> "Table 5. presents a comparison of the services available in Mat-Su and Anchorage with services suggested in the Good and Modern Addictions and Mental Health Service System. Mat-Su residents do not have access to any of the services suggested by SAMHSA in this model system."

Crisis Call Center

Report 1 of the *Mat-Su Environment Scan* also indicates there is a crisis hotline at Mat-Su Health Services (MSHS) for serving Mat-Su; however, it does not meet the American Academy of Suicidology Standard for telephone response Level I (American Association of Suicidology, 2012). Although it meets the first part of the standard, associated with having a dedicated phone number and phone line that is answered on a 24-hour crisis basis, the line is not staffed by a "person specifically on duty for the purpose of responding to crisis callers." The professional who answers the call also responds to the emergency department and has other job responsibilities. While this service is an asset to the Mat-Su community, it does not qualify as a state-of-the-art crisis call center.

AWAIC too operates a 24-hour crisis line in Anchorage for those experiencing domestic violence or its effects. Direct Service Advocates staff the crisis line. These positions do not require a degree or clinical credentials, but do require "lived experience." The crisis line staff are trained in-house at AWAIC and also receive outside training. AWAIC indicates that it does receive suicidal calls and the response offered varies based on the call. Generally the Advocate will attempt to stabilize the caller and make referrals as she or he deems appropriate or engage 911 if the caller seems at imminent risk. Most calls are not generally routed to existing suicide hotlines. While this is a necessary domestic violence service for Anchorage and beyond, it is not intended to be a comprehensive BH crisis call center.

Also in Anchorage, Providence Health and Services operates an ED Crisis Line, but it no longer has assigned staffing to support this function. Therefore, this service demonstrates similar limitations as those of MSHS in meeting minimal crisis call center standards.

At the time of the writing of *Report 1 of the Mat-Su Environmental Scan*, Alaska's statewide Careline, which serves as the State's suicide prevention hotline, had not yet been launched. Careline operates out of Fairbanks and is a 24/7 crisis call center that is funded by the Alaska's Department of Health and Social Services' Comprehensive Behavioral Health Prevention and Early Intervention Services. Careline is accredited by the American Association of Suicidology through 2022, and is a member of the National Suicide Prevention Lifeline Network. Careline touts itself as "ALASKA'S SUICIDE PREVENTION AND SOMEONE-TO-TALK TO LINE." It offers texting support from 3-11 p.m. Tuesday through Saturday, and a Careline App. The App makes Careline particularly attractive to young people and extremely accessible for those who have downloaded it. Careline also maintains a website, but it is uncertain how much traffic it

generates, particularly since it does not provide much information to support help-seeking behavior, nor does it provide reports on Careline's performance, staffing levels, or professional credentials.

Careline maintains a toll-free phone line system with an adequate number of phone lines and technology to maximize staff performance and call center operations. The system allows the call center to track and monitor calls received, and it contracts with another call center for roll-over calls which is when Careline's call volume capacity has been exceeded.

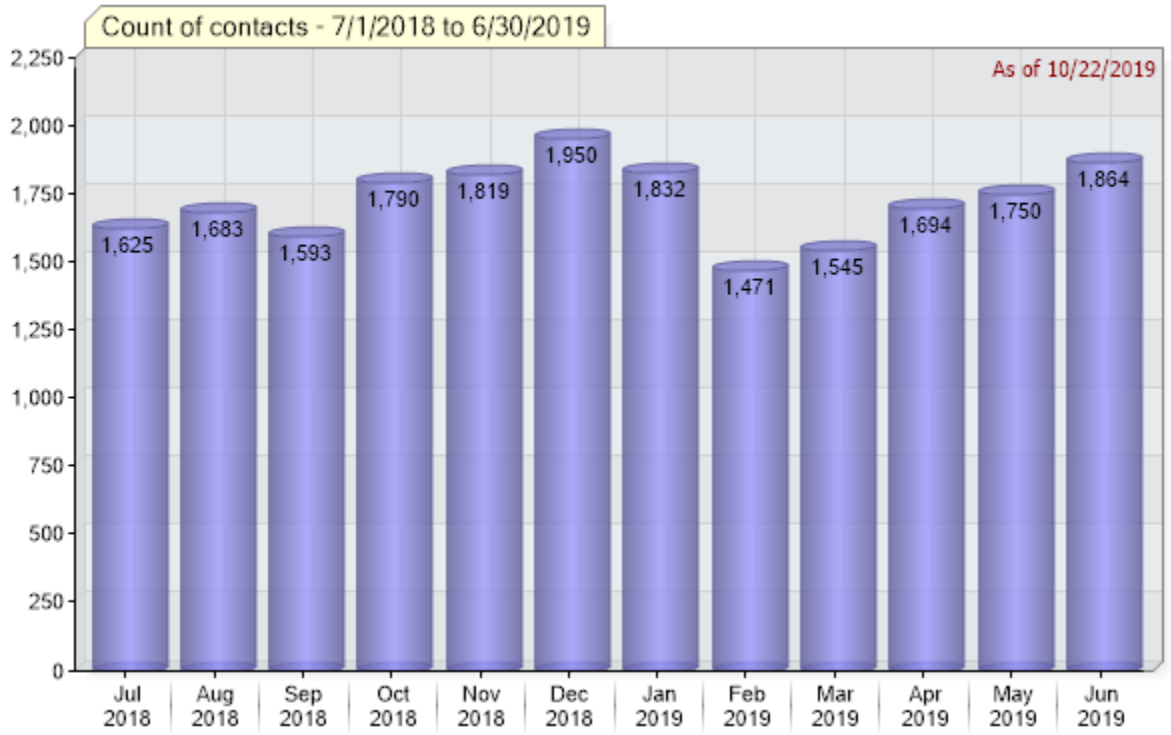
Careline's call volume has roughly doubled over the five years that it has been operational. In FY15, it received 10,270 calls and by FY19, it was processing 20,616 calls. Given that 300-400 calls per month are flagged for BH and/or suicide by Anchorage APD's 911 dispatch, if these calls were processed by Careline, its volume of calls could increase by as much as 4000 or more per year. Of these calls, 150-170 are currently being transported to a hospital. If a person doesn't go to a hospital, there are a variety of other dispositions, including jail. APD estimates that its officers are typically, spending 2-3 hours on BH calls, but some have extended up to 10 hours. Comparatively, if responding to a call where there is no arrest and no BH issues, officers can be on and off the scene in 15 to 30 minutes.

The time commitment, by all first responders in Anchorage, is exacerbated by EDs issuing diversion alerts when treatment capacity limits have been reached. While there does not appear to be any data collected to quantify these occurrences, there appears to be a dynamic in these communities, not only in Anchorage, where first responders get caught in a revolving door transiting from one ED to the next.

Any 911 call initially comes to APD. APD may transfer to AFD if the call is medical/fire in nature. If the call is BH-related, police will respond. However, they may request medics to stage if the person in crisis is at imminent risk of harm (i.e. standing on edge of a bridge). If there is a suicide attempt, AFD and APD will co-respond. Typically, AFD will not respond to Bean's Café/Brother Francis homeless shelters in Anchorage without a police presence, unless this option is not available.

Current practice does not permit APD dispatch to connect a caller to Careline; however, Careline does occasionally transfer calls to APD. This does not have to be the case. Protocols can be mutually developed and agreed to, and implemented that would facilitate all of the State's 911 dispatch call centers to transfer BH calls to Careline.

The following chart shows the monthly distribution of Careline calls for FY19:



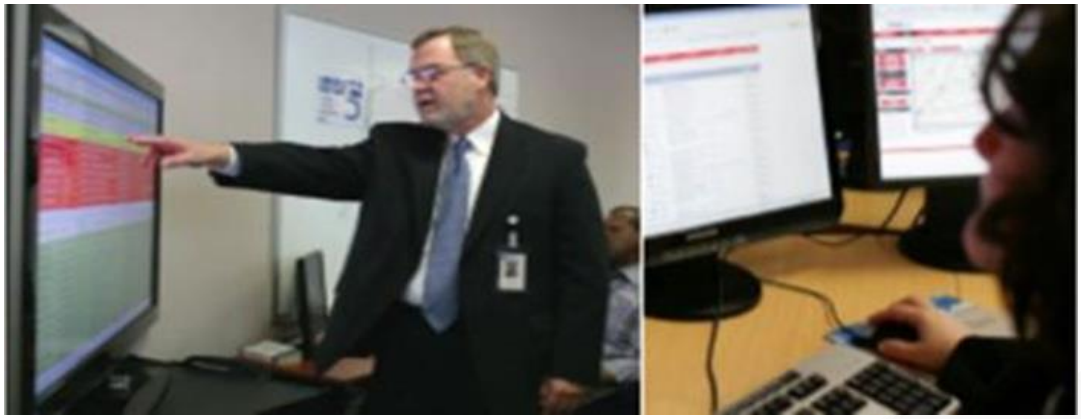
With the exception of FY16, each of the other five years, Careline's calls have distributed along a similar trend line. Call volume incrementally increases from July to January or February when there is a precipitous drop in call volume. This is the period when Alaska's incidence of suicides begins to escalate which coincides with longer days of sunlight following the long, cold, and dark winter.

Careline provides staffing to cover five (5) phone shifts per day, 7 days a week, 365 days a year and additional relief staff to respond to periods of high call volume. It also maintains staffing to provide coverage for the crisis text-line service which operates 5 days a week, for a total of 40 hours a week. All staff are provided training (including relief and volunteer staff) according to established, and emerging, best practices as defined by the American Association of Suicidology. Careline's written policies and procedures include policies regarding the provision of follow-up contacts to callers, secondary trauma therapeutic support for call center staff, and supervision and clinical consultation.

Careline holds memorandums of agreement with multiple statewide partners including law enforcement agencies, BH providers, and other health and social service providers. Careline engages in data collection, monitoring, and evaluation and analysis of call data to identify trends that can help improve performance and effectiveness. Based on current call trends, it is expected that a Crisis Call Center similar to Careline would dispatch MCTs to about ten percent of the calls coming in from Anchorage, Mat-Su, and Fairbanks. Since Careline's call volume for FY19 was 20,616 calls, it would be expected that there would be the potential statewide for approximately 2,000 MCT dispatches. In addition, most of the 9-1-1 dispatched calls would be expected to be appropriate for MCT response, since the majority of these calls have not required an EMS or ambulance intervention. In FY19, Careline dispatched first responders only 56 times in Anchorage.

Care Traffic Control Hub Model

The keystone of the *Crisis Now Model* is a 24/7 Crisis Call Center. When equipped with the technology to support Care Traffic Control, 90% of crisis calls can be stabilized and resolved without further intervention. Careline is currently a major crisis response resource for the entire State of Alaska and may be enhanced to serve as the foundation upon which the Crisis Now Model can be built. Standing up a new Care Traffic Call Center is possible, however enhancing Careline's existing infrastructure is one option available to the state which may be less expensive than starting a call center from scratch. This recommendation supports the intent of RI's consultative effort to identify assets that exist that can be optimized or built upon to support implementation of the components of the Crisis Now Model. Naturally considerations must be weighed about the feasibility of this resource, the location of operation of a Care Traffic Control Hub and other considerations such as workforce and service coordination.



Learning from Air Traffic Control Safety

The keys to advancements in aviation safety are simple. There are two vitally important objectives that, without them, make it impossible to avoid tragedy:

- Objective #1: always know where the aircraft is – in time and space – and never lose contact;
- Objective #2; verify the hand-off has occurred and the airplane is safely in the hands of another controller.

In the Air Traffic Control example, technology systems and clear protocols ensure that there is absolute accountability at all times, without fail. When an air traffic controller has the responsibility for any given plane… unless and until they seamlessly hand the responsibility to someone else, who then assumes the same level of care and attention. They simply do not allow an airplane to be unsupported and left on its own. These objectives easily translate to BH. We should always know where the individual in crisis is, and verify that the appropriate hand-off has occurred. Yet these seemingly simple objectives are missing from most of public sector BH crisis systems. Individuals and families attempting to navigate the BH system, typically in the midst of a mental health or addiction crisis, should have the same diligent standard of care that air controllers provide.

In 2006, the Georgia Crisis and Access Line was launched. The goal was to have an "air traffic controller's view" of individuals currently navigating the crisis system. This goal was accomplished through state-of-the-art technology, including an integrated software infrastructure that tracks individuals at a statewide level, with built-in assurance of consistent triage, level of care protocols, and warm hand-offs to the appropriate crisis service teams across the state. This is very different from traditional systems and can reduce the number the failures facing current systems across the country. This approach does not imply a belief that human beings can be routed like objects, nor is it an effort to force a one-size-fits-all approach on unique geographies, demographics, funding streams, and BH care systems. Rather, it ensures no individual gets "lost" in the system.

Making the Case for a Close and Fully Integrated Crisis Services Collaboration

In 2010, the Milbank Memorial Fund published the landmark report, *"Evolving Models of Behavioral Health Integration in Primary Care,"* which included a continuum from "minimal" to "close to fully integrated." This established the gold standard for effective planned care models and changed the views of what is acceptable community partnership and collaboration. Prior to this, coordination among BH and primary care providers had frequently been minimal or non-existent, and it would have been easy to accept any improvement as praiseworthy.

In fact, the Milbank report portrayed close agency-to-agency collaboration (evidenced by personal relationships of leaders, MOUs, shared protocols, etc.) at the lowest levels of the collaboration continuum. They described these community partnerships and their coordination as minimal or basic, citing only sporadic or periodic communication and inconsistent strategies for care management and coordination. They called for frame-breaking change to the existing systems of care, and their report continues to reverberate throughout the implementation of integrated care.

Required Elements of a Statewide Crisis Services "Care Traffic Control System"

The Milbank collaboration continuum (original citation Doherty, 1995) for the purposes of evaluating crisis system community coordination and collaboration (see the graphic below).

In this model, the highest level requires shared protocols for coordination and care management that are "baked into" electronic processes, not simply add-ons. For a crisis service system to provide Level 5 "Close and Fully Integrated" care, it must implement an integrated suite of software applications that employ online, real-time, and 24/7:

Status Disposition for Intensive Referrals: There must be shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels, including requirements for service approval and transport, shared protocols for Medical Clearance algorithms, and data on speed of accessibility (Average Minutes Till Disposition).

24/7 Outpatient Scheduling: Crisis staff should be able to schedule intake and outpatient appointments for individuals in crisis with providers across the state, while providing data on speed of accessibility.

Shared Bed Inventory Tracking: Intensive services bed census is required, showing the availability of beds in crisis stabilization programs and 23-hour observation beds, as well as, private psychiatric hospitals, with interactive two-way exchange (individual referral editor, inventory/through-put status board).

High-tech, GPS-enabled Mobile Crisis Dispatch: MCTs should use GPS-enabled tablets or smart phones to quickly and efficiently determine the closest available teams, track response times, and ensure clinician safety (time at site, real-time communication, safe driving, etc.).

Real-time Performance Outcomes Dashboards: These are outwardly facing performance reports measuring a variety of metrics such as call volume, number of referrals, time-to-answer, abandonment rates and service accessibility performance. When implemented in real-time, the public transparency provides an extra layer of urgency and accountability.

In addition, the system should provide electronic interconnectedness in the form of secure HIPAA-compliant, and easy-to-navigate web-based interfaces and community partner portals to support communication between service and support organizations (including emergency departments, social service agencies, and community mental health providers) with intensive service providers (such as acute care psychiatric inpatient, community-based crisis stabilization, inpatient detoxification, and mobile crisis response services). One of the advantages that Alaska has in this regard is the statewide implementation of the Emergency Department Information Exchange (EDIE). EDIE has the capability to exchange real-time data on ED dispositions. In addition, it has care coordination functionality that should be maximized in Anchorage, Mat-Su, and Fairbanks so that care is coordinated and is not restricted to crisis episodes. Interfaces should also include web-based submission forms for use by community partners to support mobile crisis dispatch, electronically scheduled referrals by hospitals as a part of discharge planning, and managed care and/or authorization requirements.

The Georgia Crisis & Access Line utilizes sophisticated software to help the crisis professional assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. Their names display on a pending linkage status board, highlighted in green, white, yellow, or red depending on how long they have been waiting.

When a person contacts the Crisis Line, they have metaphorically put their hand out and the crisis team has taken it. The answering clinician will continue holding the caller's hand until there is confirmation that someone else has successfully taken hold. A warm hand-off is not deemed successful until there is

verification that the caller successfully engaged with another entity that has accepted the clinical responsibility for the caller's care and support. This verification process is applicable to referrals to mobile crisis, law enforcement, or an emergency department. These approaches also apply for those with routine needs, who turn out not to be in crisis but have been engaged by a mobile crisis team or the crisis call center. The staff of the Crisis Line follows up with everyone, 100% of the time. As a result, despite increasing numbers of referrals flowing through the system, individuals are being accepted into care faster and more effectively.

Optimizing Careline to Become Alaska's Care Traffic Control Hub

Even organizations that maintain numerous close relationships with other service and support organizations can be extremely inefficient and ineffective when they are dependent on referral protocols that rely on telephonic coordination of care (voice mails, phone tag, etc.). Many, if not most, crisis referrals fall through these proverbial cracks in the system. The time has passed for having to continue to rely on these antiquated processes. There have been several national discussions about current system failures and the frequency by which individuals have tragic outcomes because of the failures of outmoded practices. Crisis systems must take seriously the need to avoid both near misses and tragedies, and we believe statewide community collaboration for Level 5 crisis systems are the solution. If the National Transportation Safety Board settled for a 99.9% success rate on commercial flights, there would be 300 unsafe take-offs and/or landings per day! Air traffic controllers only settle for 100% success, and Alaskans deserve no less.

The approaches described above are not hypothetical; they have been employed on a statewide basis for over 20 years in Georgia. New Mexico and Idaho added statewide crisis and access lines in 2013; Colorado launched its statewide system in 2014, and NYC Well launched in 2017. But only Georgia, has the full functionality of a Care Traffic Control Hub, and so can Alaska. This will require an additional investment in Careline to become Alaska's Care Traffic Control Hub. While other crisis line services, such as those operated by MSHS and Providence, are free to operate in their respective communities. It is the view of the RI consultant team, assuming Careline becomes Alaska's Care Traffic Control Hub, maintaining these local crisis call line resources would be an unnecessary duplication of services and would potentially confuse individuals in distress about what crisis number to call. With a statewide Care Traffic Control Hub, all crisis call traffic should be directed to it, since it will have the complete array of resources to successfully manage the crisis. This will be simplified for beneficiaries, when Careline is designated as Alaska's 233 crisis call center pending Congressional legislation authorizing this national three number designation. The AWAIC domestic violence crisis line and any rape crisis lines are deemed an exception to this recommendation and have legitimate reasons to maintain a customized service.

It would not be unreasonable for the communities of Anchorage, Mat-Su, and Fairbanks to each expect to have its own Care Traffic Control Hub. In fact, Recommendation 4a from the 2014 Mat-Su BH Environmental Scan; Report 1 – The Crisis Response System reads, "Develop a robust, crisis hotline and warm line for use in Mat-Su." Often communities view their problems as unique and prefer to be served by their neighbors, who presumably understand them better, than an outsider would. This perception however is counter-balanced by the fact that BH services are not often accessed, because the person does

not want anyone who is familiar with them to know that he or she has a BH condition that requires assistance.

A crisis call center that is statewide offers the potential for greater anonymity. In contrast to a statewide call center, Phoenix, Arizona metropolitan area, for example, has its own crisis call center, but it also has a population of 4.5 million people. Alaska, on the other hand, is estimated to currently have a total population of 735,720. With an estimated 291,538 residents in 2018, Anchorage is Alaska's most populous city and contains more than 40% of the state's total population. While Anchorage is substantially larger than either Mat-Su or Fairbanks, it does not have the efficiencies of scale to operate its own Care Traffic Control Hub, and it therefore follows that neither do Mat-Su or Fairbanks.

Careline, as noted earlier, operates a peer-to-peer warm line, but not on a 24/7 basis. In RI's experience, this warm line support service is a critical value-added service to a crisis call center. It frees up clinical staff to triage calls and provides callers with a peer support resource that is free to spend longer periods of time with the caller and provide meaningful engagement. In addition, peer support staff can participate in post-vention work that is increasingly proving to be effective in preventing crisis episodes. Therefore, the peer-to-peer warm line hours should be extended to 24/7. Likewise, the capacity for texting should be expanded from 40 hours a week to 24/7 to accommodate the needs of youth who tend to only access help via this modality. However, operating a texting services tends to cost two to three times as much as audio in terms of staffing capacity and therefore, is more costly.

One final note, regarding the optimization of Careline to become Alaska's Care Traffic Control Hub. In order for it to function as a keystone statewide resource, Alaskans need to know that this statewide resource exists and is immediately accessible. Therefore, the implementation of a sustained Careline marketing plan is critical and it should include website traffic optimization. The fact that this Hub can offer a 90% successful disposition rate is particularly critical to Alaska given its dearth of on-the-ground BH resources in remote rural and frontier areas.

If, for whatever reason, Careline Care Traffic Control Center optimization is not pursued, DHSS's Division of Behavioral Health could put this service out to bid. Opening up this opportunity to an open procurement would afford Alaska the opportunity to evaluate proposals from in-state entities versus potential bids from out-of-state vendors.

Mobile Crisis Teams (MCT)

Community-based mobile crisis is an integral part of a crisis system of care. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or ED utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving BH crises and preventing future crisis situations.

Community-based mobile crisis services typically use face-to-face professional and peer intervention teams, deployed in real time to the location of a person in crisis, in order to achieve the needed and best

outcomes for that individual. Since the mid-2000s many metropolitan area mobile crisis programs have used GPS programming for dispatch in a fashion similar to Uber, identifying the location of teams by GPS signal and then determining which team can arrive at the location of an individual in crisis the quickest.

Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff, for example, a Master's- or Bachelor's-level clinician with a peer support specialist and the backup of psychiatrists or other Master's-level clinicians. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues past the crisis period. This is the model of MCT that RI utilizes and endorses and recommends for Alaska.

In many localities, a co-responder model is used. In this model, a law enforcement officer is paired with a BH professional. RI operates co-responder teams in both WA and NC and so does APD. The Institute for Social Research at the University of New Mexico conducted a literature review on MCTs in 2016 which compared these two models, which The Institute labeled as civilian MCTs and officer/civilian MCTs:

- Both models of civilian MCTs and officer/civilian MCTs are effective in fulfilling the main goals of diversion and on-site crisis stabilization/intervention.
- Civilian MCTs are more equipped to deal with on-site treatment and swift evaluation, but may not have the training and resources to deal with potentially violent situations.
- Officer/civilian MCTs are more equipped to deal with potentially violent situations, but have less on-site treatment options because of the composition of the team.
- Civilian MCTs are proven to be able to take calls from law enforcement and respond to crises and stabilize/intervene and divert citizens.
- If violent calls are received by civilian MCTs, they most likely originate from law enforcement; but if the community civilian MCTs are dispatched to a violent situation, they can contact law enforcement to intervene.
- The officer/civilian MCTs are proven to effectively deal with persons who have acute and severe mental illness, and a high potential of violence.
- The research for civilian MCTs has not conclusively shown how they deal or can deal effectively with persons of violent potential or if they even need to deal with violent individuals at all.

RI holds that there are two factors that favor the professional/peer MCT model. These have to do with the efficacy of peer engagement and with the fact that the operational costs associated with these teams are significantly less than the co-responder model. The use of a peer specialist, as opposed to an armed uniformed officer, in responding to crises on the ground is, in itself, de-escalating. The mere presence of a law enforcement officer on the other hand, can result in an escalation of agitation by someone in crisis because his or her fears are triggered. A peer specialist is a non-threatening presence. Respectfully and authentically sharing ones lived experience, of "having been there," has a calming influence that often serves to de-escalate the crisis and hence lower the risk of violence. Hence, dealing with violent situations becomes less of a concern with these MCTs.

The co-responder model typically pairs a BH professional with a law enforcement officer. The pay and benefits to support a law enforcement officer are substantially more than for a peer support specialist and the costs associated with the development of a police officer is substantially more as well. Given these

realities and the fact that the professional/peer model has demonstrated its efficacy, and in addition RI having experience with both models, RI stands by its recommendation of the professional/peer model.

According to SAMHSA's report on crisis care (2014):

> The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995). Additional objectives may include linking people to needed services and finding hard-to-reach individuals (Gillig, 1995). The main outcome objective of MCTs is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission.

Community-based mobile crisis response teams exist in the majority of states, but few have statewide coverage. While terms describing mobile crisis care differ, these programs share common goals to:

- Help individuals experiencing a crisis event to experience relief quickly and to resolve the crisis situation when possible;
- Meet individuals in an environment where they are comfortable; and
- Provide appropriate care/support while avoiding unnecessary law enforcement involvement, ED use, and hospitalization.

Studies that were identified in the Crisis Now monograph suggest that MCTs are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to services, and better than hospitalization at linking people in crisis to outpatient services. In addition, another study from the year 2000, analyzed the effectiveness and efficiency of a MCT by comparing it to regular police intervention. The average cost per case was $1,520 for MCTs, which included $455 for program costs and $1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, MCTs resulted in a 23% lower average cost per case. These findings are dated and did not account for the array of savings associated with reductions in the utilization of EDs, hospitalization, and incarceration.

Triage and Screening

The essential functions of mobile crisis services should include triage/screening, along with explicit screening for suicidality; assessment; de-escalation/resolution; peer support; coordination with medical and BH services; and crisis planning and follow-up. As most mobile crisis responses are initiated via a phone call to a hotline or provider, the initial step in providing community-based mobile crisis services is to determine the level of risk faced by the individual in crisis and the most appropriate mobile crisis team. In discussing the presenting situation with the caller, the mobile crisis staff must decide if emergency responders should be involved.

For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve the situation. Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of triage.

Assessment

The BH professional on the MCT is responsible for completing an assessment. Specifically, the he or she should address:

- Causes leading to the crisis event, including psychiatric, substance use, social, familial, and legal factors;
- Safety and risk for the individual and others involved, including an explicit assessment of suicide risk;
- Strengths and resources of the person experiencing the crisis, as well as, those of family members and other natural supports;
- Recent inpatient hospitalizations and/or current relationship with a mental health provider;
- Medications and adherence; and
- Medical history.

As indicated earlier, following the tragic death of a Washington State social worker in 2006, the legislature passed into law a Bill relating to home visits by mental health professionals. Provisions within the Bill include the following:

- No mental health crisis outreach worker will be required to conduct home visits alone.
- Employers will equip mental health workers, who engage in home visits, with a communication device.
- BH practitioners dispatched on crisis outreach visits will have prompt access to any history of dangerousness or potential dangerousness on the client they are visiting, if available.

Given that MCTs intervene with individuals in their natural environments, including their homes, these types of safety protocols require MCT adherence.

De-escalation and Resolution

Community-based MCTs engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis. The goal is not just to determine a needed level of care to which the individual should be referred, but to resolve the situation so that a higher level of care is not necessary.

Peer Support

According to SAMHSA (2009), mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis." This is equally valid for those with substance use disorders.

For community-based MCTs, including peers can add complementary qualifications to the team so that individuals in crisis are more likely to relate to while undergoing crisis intervention and support services. Peers should not reduplicate the role of BHPs, but instead establish rapport, share experiences, and strengthen engagement with individuals experiencing a crisis. They may also engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support.

Coordination with Medical and Behavioral Health Services

Community-based MCTs, as part of an integrated crisis system of care, should focus on linking individuals in crisis to all necessary medical and BH services that can help resolve the situation and prevent future crises. These services may include crisis stabilization or acute inpatient hospitalization, treatment in the community (e.g., community mental health centers, in-home therapy, family support services, crisis respite services, and therapeutic mentoring).

Crisis Planning and Follow-Up

SAMHSA's essential values for responding to crisis include prevention. "Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and what will prevent future relapse. Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvement." (SAMHSA, 2009). During a mobile crisis intervention, the BH professional and the peer support specialist should engage the individual in a crisis planning process, which can result in the creation or update of a range of planning tools including a safety plan.

When indicated, they should then follow-up to determine if the service or services to which they were referred was provided in a timely manner and is meeting the person's needs. For example, a follow-up call within 48 hours continues to ensure support, safety, assistance with referrals and/or follow-up until the crisis is resolved or the individual is linked to other services.

Police-Mental Health Collaborations (PMHCs)

In April, 2019, the Bureau of Justice Assistance under the U.S. Department of Justice and the Justice Center of The Council of State Governments published the brief, *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs.* This brief stipulated the following:

Understanding a need for greater collaboration, many law enforcement and behavioral health agencies have begun taking important steps to improve responses to people who have mental health needs. These efforts have led to improvements in practices, such as providing mental health training to law enforcement workforces and including mental health, crisis intervention, and stabilization training as part of some states' law enforcement training standards. Stabilization training refers to tactics used to defuse and minimize any harmful or potentially dangerous behavior an individual might exhibit during a call for service. Some of these communities also designate officers to serve as part of specialized teams to respond to mental health-related calls for service. But while these steps are commendable and signify widespread acknowledgment of the need to improve law enforcement's responses to people who have mental illnesses, they also underscore the need for more comprehensive, cross-system approaches.

Communities are learning that small-scale or standalone approaches—such as just providing mental health training or having a specialized team that is only available on certain shifts or in certain geographical areas—are not adequate to achieve community-wide and long-lasting impacts. They have also learned that even the most effective law enforcement responses cannot succeed without mental health services that provide immediate crisis stabilization, follow up, and longer-term support.

Moreover, when there are limitations in data collection and information sharing, law enforcement leaders have a difficult time understanding whether the investments they have made in training or programs are working, because success is being defined by anecdotes, impressions, or even by the media's coverage of isolated, high-profile incidents instead of concrete measures and outcomes.

To address these challenges, some law enforcement agencies have invested in comprehensive, agency-wide approaches and partnerships with the BH system. These cross-system approaches, which the brief refers to as Police-Mental Health Collaborations (PMHCs), are intended to build on the success of BH training and specialized teams by layering multiple types of response models—e.g., Crisis Intervention Teams (CIT), co-responders, and MCTs—and implementing one or more of these models as part of a comprehensive approach. PMHCs are distinguished by a commitment to integrating responses to people who have BH conditions into the day-to-day functions of all officers. In PMHCs, law enforcement executives have included the initiative in their agency mission, instead of just assigning it to the exclusive domain of a specialized unit. They result in formal partnerships with community-based BH providers and organizations representing people living with BH conditions and their families; quality training on BH and stabilization techniques that is provided to all officers and 911 dispatchers; and written procedures that are clear and adhered to by staff.

RI has found that PMHCs are critical to the development and implementation of a comprehensive crisis system approach. For jurisdictions that are seeking to implement a new PMHC, the U.S. Department of Justice's Bureau of Justice Assistance provides additional background on PMHCs and the different PMHC response models in the Police Mental Health Collaboration Toolkit which is available at the following link: https://pmhctoolkit.bja.gov/.

During the course of preparing for this report, there were many expressions by various stakeholders that crisis service efforts to date have not been adequate to achieve community-wide and long-lasting impacts. As a result, there are efforts underway in Anchorage, Mat-Su and Fairbanks to layer multiple types of response models which is apparent throughout this Report. However, these efforts have been in the absence of a comprehensive approach.

Current MCT Operations

As indicated earlier, MCTs can take different forms and this appears to be no less true in the three communities included in this report. Providence Health and Services used to have a MCT operating in Anchorage. The team members were employees of Anchorage Community Mental Health Services who were assigned to Providence. When the team was housed at ACMHS, it was a two-person team, but when it moved to Providence, it became the responsibility of a single individual. Issues ensued because there would be times when the mobile crisis person was inactive and Providence's other ED clinicians were overwhelmed by service demands. Providence, in response, began re-deploying this person to assist in the ED and, as a result, this person was unavailable to respond to crises in the community. Providence indicated during our interview, that it is supportive of the re-establishment of MCTs, but only if they are staffed and supported appropriately.

ACMHS currently operates a specialty MCT that is offered in conjunction with its Permanent Supportive Housing Voucher Program in partnership with Neighborworks Alaska. This service is available 6 days a week, 10-12 hours per day. While this is a critical service to those enrolled in this program, it is not a MCT that can be deployed to respond to crisis calls generally within the larger community.

The Crisis Response Team of the Anchorage Police Department has been piloted within the last year as a co-responder program that functions as a Crisis Response Team. It is now fully implemented. An APD officer is paired with a BH clinician during the day shift from 9am to 6pm. The Team responds to crisis calls from 911 dispatch, takes a portion of active calls, works with high utilizers and does some follow-up. Cases that have been engaged are tracked in a database, but not all of the APD officers have access. APD appears to be still assessing how to maximize the use of this resource by all deployed officers. Again, this is an important MCT resource, but it alone is insufficient to meet the needs of the Municipality and it is not electronically linked with a broader crisis response network.

The Anchorage Fire Department (AFD) operates and dispatches the Anchorage Safety Patrol which is a two person team consisting of an Emergency Medical Technician (EMT) and a support person. The Patrol does wound care, patient follow-up, and informal crisis negotiation. In addition, it oversees the Community Outreach, Referral, and Education (Core) Team which serves the high-utilizers of the AFD.

The Anchorage Coalition to End Homelessness (ACEH) is working to organize a community response to homelessness. The new vision for coordinated entry is a 24-hour hotline, mobile response, and places that people could come to receive services. They are interested in building out navigation that serves and follows the person. ACEH is very interested in the connections between their work and what is presented in Crisis Now.

According to the Palmer Police Department there is simply nothing in Mat-Su in terms of crisis response. Apparently, there are two options available to their officers – Mat-Su Pretrial or Mat-Su Regional. However, for the last three years a strong Crisis Intervention Coalition has formed that has trained a majority of first responders in Mental Health First Aid and a robust group have attended a week long Crisis Intervention Team Academy. This group that includes BH providers, MSRMC staff, borough EMS, law enforcement, and other first responders, has driven change in the borough and is poised to assist with the improvement in crisis intervention response. The disposition options for law enforcement in Fairbanks is similar to the Mat-Su Valley. Fairbanks is focused on broader implementation of trained emergency responders in the CIT model.

It is evident that in the absence of a comprehensive BH crisis response system, various organizations have taken the initiative to fill some of the gaps in crisis services. Others are actively working on plans to implement various components of a crisis system, but often these plans are developed within a context of having to address a specific need or population. Too often, this can result in a duplication of effort and the implementation of solutions that do not have sufficient bandwidth to adequately address the crisis needs of a state, a region, or a given community. Despite these well intended efforts, no one organization has the resources to adequately do the job, and as result, there is a patchwork quilt of services that have no way of tracking and monitoring individuals from one organization to another. In Care Traffic Control terms, "there is no way to ensure that everyone in crisis, will have a safe landing."

With a Care Traffic Control Hub that is adequately resourced to dispatch and track MCTs statewide, in the areas with sufficient population density to make them workable, Alaska would have the means to offer over 90% of its population an appropriate, immediate, and urgent BH crisis response. It would be expected that 70% of those callers without a satisfactory disposition, would be appropriate for dispatching of a MCT which based on current Careline call volume, would be at a minimum 1400 MCT dispatches per year. Since the combined population of Anchorage, Mat-Su, and Fairbanks represents 67.5% of Alaska's total population, the expected MCT dispatches for these three localities would be 945. The remaining 455 calls that would be appropriate for a MCT dispatch would be in more rural and frontier communities that would require alternative community-based crisis responses. Suggestions regarding these financing alternatives will be highlighted in the conclusion section of this report. Also included, will be recommendations regarding the financing of MCTs, since Medicaid and other forms of health insurance are not usually adequate to sustain MCTs.

Crisis Observation and Stabilization Facilities

Many individuals in crisis brought to hospital EDs for stabilization report experiencing increased distress and worsening symptoms due to noise and crowding, limited privacy in the triage area, and being attended to by staff who had little experience with psychiatric disorders. All of this increases frustration and agitation (Clarke et al., 2007). Agar-Jacomb and Read (2009) found individuals who had received crisis services preferred going to a safe place, speaking with peers and trained professionals who could understand what they were experiencing, and interacting with people who offered respect and dignity to them as individuals, an experience they did not have at the hospital. In such an alternative setting, psychiatric crises could be de-escalated.

In its review of crisis services, SAMHSA (2014) defined crisis stabilization as:

> "A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery."

Crisis residential facilities are usually small (e.g., under 16 beds), and often more home-like than institutional. They are staffed with a mix of professionals and para-professionals. They may operate as part of a community mental health center, in affiliation with a hospital, or a stand-alone facility operating by a non-profit provider organization. Crisis stabilization facilities function is maximized when the facilities:

- Function as an integral part of a regional crisis system serving a whole population, rather than as an offering of a single provider
- Operate in a home-like environment
- Utilize peers as integral staff members
- Have 24/7 access to psychiatrists or Master's-level BH clinicians

Evidence on Effectiveness and Cost-Effectiveness of Crisis Stabilization Facilities

In general, the evidence suggests a high proportion of people in crisis who are evaluated for hospitalization can safely be cared for in a crisis facility, the outcomes for these individuals are at least as good as hospital care, and the cost of crisis care is substantially less than the costs of inpatient care. SAMHSA (2014) summarized the evidence on crisis stabilization facilities as follows:

> "The current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning. It also demonstrates that the satisfaction of these services is strong, and the overall costs for residential crisis services are less than traditional inpatient care. For the studies examined in this review, the populations range from late adolescence (aged 16–18 years) through adulthood. Regarding mental health and crisis residential, a recent systematic review examined the effectiveness of residential alternatives to hospital inpatient services for acute psychiatric conditions (Lloyd-Evans, et al., 2009). This review included randomized control trials or studies that provided specific quantitative comparisons of effectiveness of alternatives to standard acute inpatient care. The authors concluded that there is preliminary evidence to suggest residential alternatives may be as effective as and potentially less costly than standard inpatient units."

Small, home-like crisis residential facilities are a necessary, core element of a crisis system of care. To maximize their usefulness, crisis residential facilities should function as part of an integrated regional approach within a state serving a defined population (as with MCTs). Access to the program should be facilitated through the Care Traffic Control Hub which monitors the trajectory of crises throughout the state and regionally. In this way, those that ultimately need the benefits associated with facility-based care can readily access it. But access is also readily available to first responders such as law enforcement and EMS.

Safety for both consumers and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality, an issue with life and death consequences. And while ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised. People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been brought in by law enforcement, and thus may present an elevated risk for violence.

Trauma-informed and recovery-oriented care is safe care. But much more than philosophy is involved. DHHS's Mental Health Crisis Service Standards (2006) begin to address this issue, setting parameters for crisis services that are flexible and delivered in the least restrictive available setting while attending to intervention, de-escalation, and stabilization.

- The keys to safety and security in crisis delivery settings include: Evidence-based crisis training for all staff.
- Role-specific staff training and appropriate staffing ratios to number of clients being served.
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent. Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures.
- Pre-established criteria for crisis system entry.
- Strong relationships with law enforcement and first responders.

Ongoing staff training is critical for maintaining both staff competence and confidence, and promotes improved outcomes for persons served and decreased risk for staff (Technical Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and clients in the crisis setting.

Adequate staffing for the number and clinical needs of consumers under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers, peer support professionals) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to self or others (NASMHPD, 2006).

In some crisis facilities that are licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. If the facility is to operate under a "no wrong door" approach, it is imperative that the crisis facility be able to accommodate involuntary admissions. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both clients and staff; and often end up re-traumatizing individuals who have experienced physical and emotional trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as a threat or act of punishment, alternative to staffing shortages or inadequacies, as a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

The National Association of State Mental Health Program Directors (NASMHPD) (2006) has postulated a set of core strategies for mitigating the use of seclusion and restraint. These include employing BH leadership that sets seclusion and restraint reduction as a goal, oversight of all seclusion/restraint for performance improvement, and staff development and training in crisis intervention and de-escalation techniques.

Person-centered treatment and use of assessment instruments to identify risk for violence are also critical in developing de-escalation and safety plans. Other recommendations include partnering with the consumer and his or her family in service planning, as well as, debriefing staff and consumers after a seclusion/restraint event, to inform policies, procedures, and practices to reduce the probability of repeat episodes that result in the use of such interventions.

Ensuring the safety of both consumers and staff is the very foundation of effective crisis care. While safety is urgently important in all of health care, in crisis care, maintaining a safe and welcoming environment is essential. The prominence and damaging effects of trauma and the fear that usually accompanies psychological crisis make safety truly "Job One" in all crisis settings.

Ashcraft (2006) and Heyland et al. (2013) describe an alternative crisis setting called "the living room," which uses the recovery model to support an individual's stabilization and return to active participation in the community. Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose. Individuals in crisis are admitted as "guests" into a pleasant, home-like environment designed to promote a sense of safety and privacy. A team of "crisis competent" professionals, including peers with lived experience, engages with the guest. Risk assessment and management, treatment planning, and discharge goals are set. A peer counselor is assigned to each guest to discuss the guest's strengths and coping skills that can be used to reduce distress and empower the guest on his or her recovery journey.

Preferably, these facilities are available for direct drop-off by law enforcement and/or EMS. This advanced practice can avoid both criminalization of crisis-induced behavior, as well as, the costs and potential trauma associated with hospitalization and/or incarceration. If it is determined a guest continues to pose a safety threat to self or others, he or she may be subject to seclusion and restraint, but only as a last resort. Rarely, is a guest transferred to a more intensive level of care. Likewise, upon medical screening, roughly 4% on average, require a medical transfer which the facility arranges with the expectation that the guest return upon the completion of medical intervention.

"No Wrong Door," has become the motto for these facilities since everyone that presents, whether a walk-in or a police drop-off, whether actively psychotic, violent on methamphetamines, or suicidal, is admitted. There is no need for medical clearance in order to be accepted. There is no "diversion," which seems to be a common practice among the EDs in the three communities, when their respective capacities have been overwhelmed, often by BH crises. In addition, law enforcement is not called back to the facility after drop-off because the facility has been unsuccessful at de-escalation. The entire milieu of the facility is designed to assure that guests and staff are kept safe. This extends from the design of the facility, the staffing ratio, the team work culture, the use of "milieu specialists" who are "bulked-up" peers who engage guests who are being challenged with self-regulation. They serve as an alternative to security guards whose mere presence can escalate situations.

The average length of an observation stay is only 7-10 hours. This is again possible because of the milieu and the culture of this "living room" approach. There are no beds in these settings, but instead recliners and they are typically arranged to facilitate interaction with other guests and with staff. With 16 - 24 recliners instead of beds, this unit is a high speed assessment, observation, engagement, and stabilization service. Each guest (patient) admitted receives the following services: a psychiatric evaluation by a Licensed Psychiatrist or Psychiatric Nurse Practitioner that includes a risk assessment and medication evaluation; a brief medical screening by a registered nurse to ensure that co-occurring medical issues are addressed; Substance Use Disorder (SUD) screening and Assessment by a licensed clinician; a psychosocial assessment by a licensed clinician; crisis stabilization services utilizing a high engagement environment with a strong recovery focus and peer support model; and comprehensive discharge and coordination of care planning.

Often under the same roof as the 23 hour observation facility, Crisis Stabilization Centers (also known as short-term crisis stabilization units, crisis triage centers, and crisis response centers or recovery centers) are home-like environments that address BH crisis in a community-based BH provider setting or in some instances are affiliated and operated by a hospital. These are bedded units that range from 6-16 beds and are staffed by licensed and unlicensed peer support specialists, as well as, clinical and non-clinical professionals. (SAMHSA, 2014; Mukherjee & Saxon, 2017). Services typically consist of assessment, diagnosis, abbreviated treatment planning, observation and engagement, support, individual and group therapy, skills training, prescribing and monitoring of psychotropic medication, referral, and linkage to community resources. Services are provided on a 24-hour basis to address immediate safety needs, to develop resiliency, and to create a plan to address the cyclical nature of BH challenges. The National Alliance for Suicide Prevention (2016) considers Crisis Stabilization Centers to be a "core element" of BH crisis systems. Different from the Living Room Model and the 23-Hour Crisis Observation Unit, Crisis Stabilization Centers offer services to individuals who are unable to be stabilized in under 24 hours and who conditions may be exacerbated by co-morbidity and complex social needs. In RI's experience, Crisis Stabilization Centers have an Average Length of Stay (ALOS) of 2-3 days.

Many communities have only two basic options available to those in crisis, and they represent the lowest and highest end of the continuum. But for those individuals whose crisis represents the middle of the ladder, outpatient services are not intensive enough to meet their needs, and acute care inpatient services are unnecessary. Crisis stabilization facilities offer an alternative that is less costly, less intrusive, and more easily designed to feel like home.

Alaska Crisis Facility Options

In Anchorage, Officers have a choice between the three hospitals (ANMC, Alaska Regional, and Providence). Providence is the first choice of APD because it operates a 7 bed Psychiatric Emergency Department. Title 47 is typically used by APD to involuntarily place someone at a hospital if they are suicidal, homicidal or gravely disabled. APD must figure out which hospital(s) are on divert. Once they arrive, APD fills out the paperwork and debriefs the nurse. If the individual is discharged from the ED to a psych facility, they may be discharged to API or the Designated Evaluation and Treatment (DET) Program units in Juneau or Fairbanks. For individuals whose primary presenting problem appears to be intoxication, APD will transport to the Anchorage Safety Center. The Safety Center admits those with a SUD and releases them once blood alcohol levels are reduced to a safe threshold. If an individual is suicidal and intoxicated, they will be transported to an ED. APD deems alcohol as the number one problem, but methamphetamines runs as a close second. APD continues to encounter more methamphetamine use than heroin, despite the opioid epidemic. Generally, individuals using methamphetamine and heroin are transported to the ED. Before a patient can be transferred to API, an assessment must be done to show they are gravely disabled and/or a danger to themselves or others and a magistrate must make that finding in accordance with the civil commitment statutes.

ALOS at API is 13 days if outliers are removed. Cost of care at API is $1555/day. About one-third of patients are coming in for a medication stabilization. Although API has 80 beds, only 48 of them are available on average for adult acute psychiatric care. API has historically operated 10 adolescent beds for 13-17 year olds, 10 beds for medium security forensic cases and 10 beds for people who need extended care that is unavailable elsewhere in the state including individuals suffering from Alzheimer's disease and the remainder for severely mentally ill patients. However, due to a host of challenges being experienced by API, two of its units are currently closed and only 48 beds are in operation which further exacerbates the problems associated with normally low number of beds and the high demand. These dynamics tend to perpetuate high admission rates and low average length of stays.

API does not operate like most state psychiatric hospitals around the country. Utilization per 1,000 people in Alaska is more than triple the national average for state hospitals (1.66 compared to .44 in FY 2015). Admission rates are significantly higher than the national average and continue to grow. API's admission rates and ALOS are more similar to hospitals that provide short-stay acute treatment and stabilization. Acute-care hospitals, often privately run, act as gatekeepers to state psychiatric hospitals which serve more complex cases requiring longer term care.

Stakeholders have indicated that one of the biggest needs in Mat-Su is for a crisis stabilization facility. Mat-Su Regional Hospital has two rooms dedicated for psychiatric patients. If these beds are full, the ED will temporarily repurpose a couple of other beds when able; but more often than not, the ED assumes diversion status, but the EMS has nowhere else to deploy. Because of this, EMS still transports BH patients to the ED. Mat-Su EMS does not have any hard data to offer regarding these calls. They have considerable raw data, but they have never had an effective operating management system or the analytics to generate valid and reliable reports. An EMS data study is currently underway and should be completed within the near future. It is anticipated to have the necessary data points to produce usable reports.

In 2017, Mat-Su Regional Medical Center applied for a certificate of need to add 16 psychiatric and substance abuse inpatient beds, the first acute inpatient BH services to be provided in Mat-Su Borough. The project was in response to the dramatic increase in the need for BH services at MSRMC. Since 2014, BH assessments for patients in acute psychiatric crisis have nearly tripled, from 349 to 1,100. The number of times the ED has had to divert psychiatric emergencies because the hospital was at capacity, has escalated even more, from five times in 2012 to 234 times in 2016. These new inpatient beds are anticipated to serve both voluntary admissions and involuntary admissions under Title 47 of the Alaska Statues. New construction is projected to be completed by December 2020.

Alaska Troopers at the Palmer Post rely on EMS to transport BH patients, if crisis services are available. The Troopers contend that they have worked hard to establish and maintain relationships with EMS. Given that there are a finite number of resources in the community, the Troopers attempt to be strategic when using them. If Mat-Su Regional is on diversion status, Troopers will frequently drive to Anchorage to try and get an individual in a BH crisis admitted to a hospital there, but too often experience being diverted there as well. A case illustration was offered to highlight the seriousness of this situation: an EMS and a Trooper were out of commission for a total of nine hours due to the challenges associated with transport.

The ED of Fairbanks Memorial Hospital operates a set of 4 seclusion rooms and a few additional examination rooms to accommodate BH crises, whether walk-ins or police drop-offs. Patients are triaged in the seclusion rooms and when necessary medicated. If it is determined that admission is appropriate, they will be transferred to the upstairs of the hospital to the Behavioral Health Unit, which has a total of 16 beds. The ED does not like to transfer up to the floor if there is a community provider involved. It is voluntary at that point. There are also 10 detox beds available in Fairbanks operated by Fairbanks Native Association.

The addition of psychiatric capacity at Mat-Su Regional Medical Center will go a long way to relieving the stress on the entire crisis response system, not only in Mat-Su but also in Anchorage and to some extent in Fairbanks. If the planning for this additional psychiatric capacity can be modified to more closely resemble the features of *Crisis Now* and when operational, function within the framework of a total *Crisis Now* comprehensive solution for Alaska, the more efficacious this development will be in both relieving the stress of the current system while also producing better and safer outcomes for those who experience BH crises, as well as, those who respond to them.

While Mat-Su Regional Medical Center's leadership around this issue should be applauded as a most significant development, it is not the total solution as expounded within this Report. Nor does it completely negate the need for the establishment of crisis observation and stabilization facilities. Within the conclusions and recommendations section of this Report, there is further direction around the specifics required to establish alignment with the Crisis Now Model.

Conclusions and Recommendations

Each recommendation within the Report has been organized within the context of the *Crisis Now Model* balanced against the needs and the strengths of the current BH service delivery services operating within

the communities of Anchorage, Mat-Su, and Fairbanks. In addition, each recommendation, when appropriate, includes specific policy and operational details that outline the number of crisis facilities, programs, and services needed along with the capacity, infrastructure, and cost estimates for each.

1. Crisis System Accountability

Establish an organizational entity to be responsible and accountable statewide for the implementation, oversight, and resourcing of the Alaska BH crisis response system and to assure that this system is developed and sustained with high-fidelity to the Crisis Now Model; and likewise, determine the entities to be responsible and accountable at the regional or local level, for overseeing the various components of the crisis response system and assure that it operates as a maximally functional system.

Given the complexities of state government structure and financing, it is important that the authority responsible for the BH crisis service system be clearly identified. Historically it would be expected that the single state BH authority, in this case DBH, would assume this role. But with Medicaid being the major payer of BH services and with an ASO now operating under DBH, this authority becomes more nebulous. Without a clear designation of authority, the responsibility for leadership for BH crisis services becomes diffuse, making it difficult for any one entity to be held accountable for the implementation and management of a crisis system with high fidelity to the *Crisis Now Model*.

This need becomes equally as important at the borough level so that local planning, financing, and monitoring of BH crisis service adequacy and quality is relevant to the local community. For the Municipality of Anchorage, which does have a Health Department and within it, a Human Services Division, this may be the appropriate entity to be resourced and assigned the authority for overseeing the development and implementation of the relevant local components of *Crisis Now* in collaboration with the State. Currently, the Anchorage Human Services Division manages the contract for the Anchorage Safety Patrol (ASP) and Safety Center (ASC), the Alaska Domestic Violence & Sexual Assault Intervention Program, Emergency Outreach Services, and the Aging and Disability Resource Center. Adding this additional responsibility for *Crisis Now* appears to be a logical extension of its current portfolio of services.

In the Matanuska-Susitna Borough governmental structure, there is not a health and/or human services entity. Instead, the Borough relies heavily on the Mat-Su Health Foundation and on the Mat-Su Regional Medical Center (MSRMC) for its health-related planning and services. It is recommended that MSHF, MSRMC and the Mat-Su Borough assemble a BH Crisis Services Steering Committee with local stakeholders to design a BH crisis system which will adapt the Crisis Now model to meet the needs of Mat-Su residents.

The Health and Social Services Commission of the Fairbanks North Star Borough has within its mission to identify the health and social goals and needs of the community and to stimulate coordination and maximum use of existing and planned facilities, services and human resources to

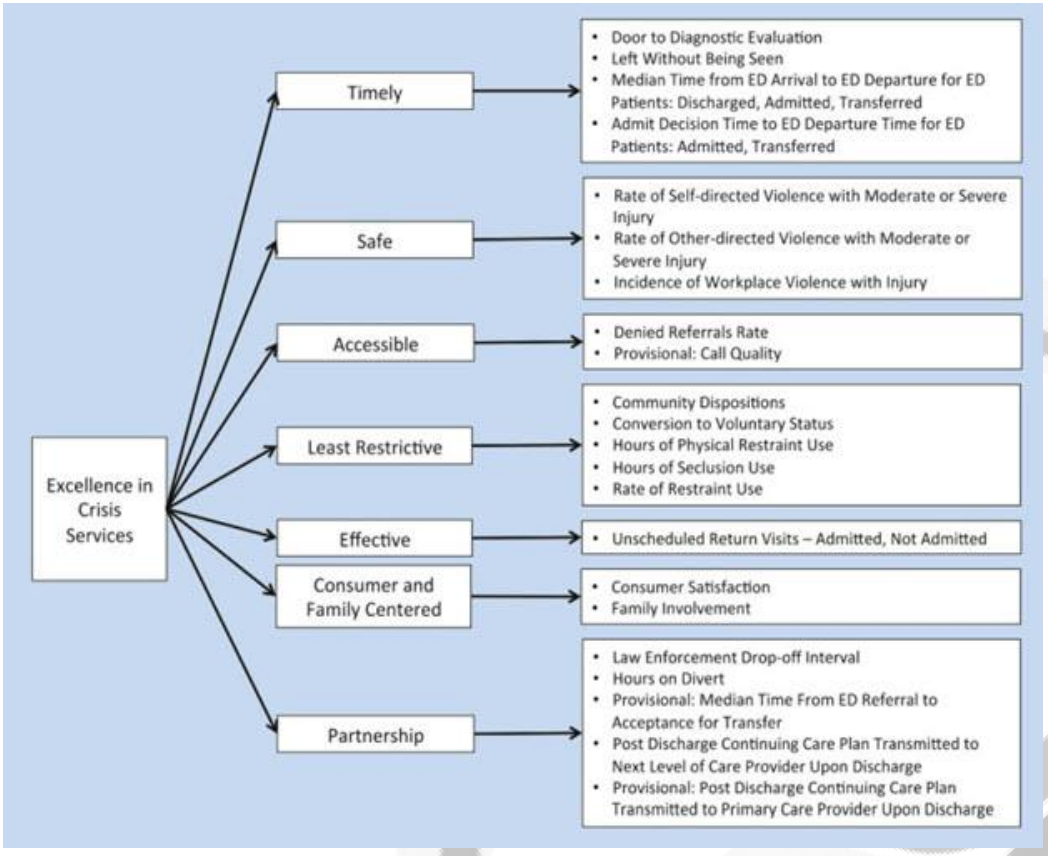
meet these identified community needs. This appears to be the logical entity to assume the authority for the local *Crisis Now* system.

2. Performance Expectations and Metrics

Establish performance expectations and metrics for each component of the crisis response system and the data systems to collect the information necessary to manage, analyze, and report on the performance of each crisis system component and the system as a whole.

For guidance on developing a framework for developing crisis performance, see Appendix A and Dr. Margie Balfour's journal article, *"Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs,"* Community Mental Health Journal, 2015, (available at: https://www.ncbi.nlm.nih.gov/pubmed/26420672) which includes the outcomes model below:

Crisis Reliability Indicators Supporting Emergency Services Framework



3. Policy and Regulatory Alignment

Continue the alignment of the following elements in support of the full implementation of the Crisis Now Model in Alaska:

a. Statutes that will permit involuntary admissions to crisis response facilities;

According to *Title 47. Welfare, Social Services, and Institutions, Chapter 30. Mental Health Article 9. Involuntary Admission for Treatment, Sec. 47.30.760*. Placement at closest facility, "Treatment shall always be available at a state-operated hospital; however, if space is available and upon acceptance by another treatment facility, a respondent who is committed by the court shall be placed by the department at the designated treatment facility closest to the respondent's home unless the court finds that:
(1) Another treatment facility in the state has a program more suited to the respondent's condition, and this interest outweighs the desirability of the respondent being closer to home;
(2) Another treatment facility in the state is closer to the respondent's friends or relatives who could benefit the respondent through their visits and communications; or
(3) The respondent wants to be further removed from home, and the mental health professionals who sought the respondent's commitment concur in the desirability of removed placement."

While the existing Title 47 statute does not directly address the placement of involuntary commitments in crisis facilities, it appears that there is a potential for such placements in crisis observation and stabilization facilities as an alternative to a state-operated facility. The State of Alaska should determine whether the current Title 47 statute is adequate to allow involuntary admissions to crisis observation and stabilization facilities or whether the existing statute should be amended.

b. Facility licensure standards that support all of the direct service *Crisis Now* program components;

Presently there are no licensure standards for Crisis Observation and Stabilization Facilities. Licensing standards are not only important for protecting the health and safety of Alaskans admitted to these facilities when available, but also to assure that the standards that are promulgated conform to the *Crisis Now Model* and to assure that all third party payers will reimburse for services provided within these settings. There are some key questions that will need to be answered by DHSS before proceeding with the drafting a set of licensing standards for these facilities:

- Is the current statute, *Title 47. Welfare, Social Services, and Institutions, Chapter 30. Mental Health Article 9. Involuntary Admission for Treatment, Sec. 47.30.760* adequate to allow for involuntary admissions to crisis observation and stabilization facilities?
- Does the State of Alaska require the passage of an enabling statute to give DHSS the authority to license crisis facilities or is this authority subsumed under existing statutes?
- Given that both types of crisis facilities, the 23 hour crisis observation center and the 16 bed crisis stabilization center, are community-based services, but admit the same level of acuity as a psychiatric ED or psychiatric inpatient unit, what facility type(s) will these facilities be considered to be operating? Some states have considered the 23 hour observation center to be an outpatient or residential service because of the absence of beds, while considering the crisis stabilization

facility since it has beds, as either a hospital or residential facility. It is recommended that DHSS designate these crisis facilities as a separate facility or provider category entirely to distinguish them from a hospital, residential facility, or an outpatient service. This separate licensing designation will avoid the considerable confusion and potential conflict that comes when negotiating contracts with third-party payers and establishing the appropriate payment rates for a high acuity service.

- Given that the national accrediting bodies for health care, have accreditation standards for crisis facilities, should the State of Alaska consider deemed status in lieu of State licensing? This would potentially shortcut the need for the promulgation of licensing standards, but it may require the promulgation of an administrative rule delineating a deemed status provision, unless it can be subsumed under an existing deemed status rule.

c. 1115 CMS Waiver provisions that support Medicaid payment for services rendered by crisis facilities;

According to the Alaska Department of Health and Social Services, in January 2018, Alaska applied to the Centers for Medicare and Medicaid Services for approval of an 1115 BH waiver at the direction of the Alaska Legislature through SB 74. The intent has been to create a data-driven, integrated BH system of care for Alaskans experiencing serious mental illness, severe emotional disturbance, substance use disorder (SUD), co-occurring substance use and mental illness, and at-risk families and children.

At the guidance of CMS, the SUD component was broken out separately from the rest of the BH services to move it forward more quickly in response to the growing opioid problem. It was approved in November 2018, with the implementation plan receiving approval in March 2019. The BH component received approval in September 2019. Once new state regulations are in place, a full array of 1115 Medicaid substance use disorder and BH services will help Alaskans with BH needs across the continuum of care. These services include, but are not limited to mobile outreach and crisis response services.

This approved Medicaid Waiver paves the way for Alaska to use its Medicaid resources to sustain *Crisis Now Model* facilities and services. Now the Medicaid Administrative Rule promulgation process should be expedited so that the *Crisis Now* facilities and services can be developed and operationalized. In addition, it is imperative that these rules align with any licensing or certification standards that may be promulgated for these facilities and services, as well as, for the peer support specialist provider type.

d. Medicaid administrative rules that recognize the crisis response continuum of care to include the crisis call center, MCTs, crisis facility types and the array of provider types employed therein;

Alaska's approved Medicaid Waiver paves the way for Alaska to use its Medicaid resources to sustain *Crisis Now Model* facilities and services. Now the Administrative Rule

promulgation process should be expedited so that the *Crisis Now* facilities and services can be developed and operationalized.

e. Medicaid payment rates and types of reimbursement that make a robust crisis system in Alaska sustainable in the long term;

Approaches to fund BH crisis services vary widely from state to state. In many cases, it is cobbled together, often inconsistently supported and inadequate to sustain these services over the long term. One of the greatest factors contributing to these funding challenges is the inconsistent expectations around crisis provider service delivery; allowing providers who staff and operate in very different ways to utilize the same crisis stabilization service coding. The nature of crisis care in systems with multiple payers must also be considered. If a provider commits to fully align their practices to the *Crisis Now Model*, then that provider is poorly positioned to negotiate reimbursement with each of those multiple funders simply because the funder knows the provider will accept all of its member referrals and serve them, even if the level of reimbursement is inadequate to cover the cost of care. In these cases, it is often local jurisdictions that are paying in part to make up for the payment shortfall of the health plans that should be responsible for appropriate payment. It is recommended that Alaska create a Medicaid rate structure that sustains delivery of crisis services that align with *Crisis Now,* and secure capacity funding for residents who otherwise do not have insurance to cover critical care. This is not a new concept given that funding streams exist in support of 911 dispatch, fire, ambulance and emergency department services, but one that must be extended for BH crisis care.

<u>Crisis Care Funding vs. Emergency Care Funding</u>

It is revealing to compare BH crisis care to other first responder systems like firefighting or emergency medical services (EMS). There are striking similarities:

- The service is essential and may be needed by anyone in the community;
- The need for it is predictable over time, but the timing of individual crises events is not; and
- Effective crisis response is lifesaving and much less expensive than the consequences of inadequate care.

For EMS, its effectiveness can be measured in terms of lives saved because of timely interventions for individuals with acute heart disease. For BH crisis response, the impact of comprehensive approaches requires measurement in terms of lives saved from suicide and other tragic fates. It would be unthinkable for any community, except perhaps in the more remote areas, to go without a fire department even if voluntary. Because this is known to be an essential public expenditure, fire stations and fire trucks are made available. Sometimes users may pay a fee for service calls, but the station and the equipment are available to anyone in need regardless of ability to pay. In most communities, BH services take a different approach or no offering at all due to the lack of

coverage or reimbursement for this level of care. Health coverage (e.g., Medicaid) will pay for professional fees as if services were delivered as part of a routine office visit, but few entities pay for the infrastructure of a crisis system with rates reflecting the need to be immediately available for the next call or referral.

Fire and/or an ambulance respond quickly to deliver emergent care. If they assess a need for further support, they may transport to the nearest ED for care. What follows in the subsequent weeks, is the delivery of bills or invoices that have gone to the person's insurance for the ambulance care and transportation, followed by any ED services. These bills or invoices total thousands of dollars in most cases; expenses that represent the higher cost of offering emergent care that is accessible to everyone, everywhere and every time. Unfortunately, BH crisis care reimbursement is often a fraction of its physical health counterparts and is, therefore, delivered in a model that falls short of best practice expectations or is simply not offered, because there is no mechanism to adequately reimburse the cost of this level of care. It is recommended that Alaska, where appropriate, consider modeling it crisis system reimbursement structure after that of emergency medicine which is already in place.

24/7 Crisis Care Traffic Control Center Hub

This service extends to the entire State in a manner similar to 911. Although there is some ability to verify certain information regarding a crisis caller by phone, many callers prefer to remain anonymous and/or are unable to provide any health plan enrollment information. Therefore, reimbursement for care using the Behavioral Health Hotline code cannot sustain a call center such as Careline. Currently Careline is primarily supported by a $400,000 state grant, but this is insufficient funding to extend all of its services 24/7 and to provide the technology required to make a Care Traffic Control Hub. Alaska might be best served through a population-based funding stream to support this service that comes from an assessment on cell phone and/or land line utilization. This approach more cleanly solidifies sustainable funding for this safety net service.

Arizona's two crisis call centers are able to bill for call triage services to Medicaid enrollees under case management billing codes which helps to subsidize this service. Alternatively, New Mexico subsidizes its statewide crisis and access line using the Medicaid administrative federal match (FMAP) of 50% which covers roughly 25% of the call center's costs. Assuming the anticipated 988 federal crisis call phone number appropriation to increase the Mental Health Block Grant to states by $35 million is enacted, there will be additional monies available to assist Alaska to further support this service.

Mobile Crisis Teams (MCT)

Crisis mobile response services are analogous to fire and ambulance responses for physical health emergencies. As such, funding mechanisms should align so that adequate capacity can be in place to serve Anchorage, Mat-Su, and Fairbanks in particular, given their

population density is sufficient to support MCTs. Given that demand is not completely predictable, each MCTs will experience periods of low utilization. Hence, reimbursement rates must be set at a level to maintain the service while the payer can still realize value with the service (will largely be value realized by avoiding ambulance and emergency department bills) and beneficiaries receive better and accessible care. If commercial and Medicaid plans pay at the established Medicaid reasonable rate, the state, or borough funding will be relatively low; particularly given Medicaid expansion and low uninsured rates.

Crisis Observation and Stabilization Facilities

Crisis observation and stabilization facilities are analogous to the acuity found in psychiatric ED. But when it comes to billing, they typically fall under some crisis stabilization claims coding that offers payment via hourly and per diem reimbursement. Most states struggle with how to best fit these facilities into an existing facility license and provider type structure that results in crisis observation centers to be licensed as outpatient programs. Often this is the only way that a state may have, under existing regulations, to offer the flexibility to deliver care using recliners instead of beds to a larger number of people in smaller spaces; and necessitating that service duration be limited to under 24 hours. Professional fees are usually billed in addition to the per diem, but could be billed as a bundled service, if preferred. The benefit of separate billing for professional services is that most third-party payers currently reimburse for professional services, while few outside of Medicaid recognize crisis facility reimbursement. Getting some of the expense covered by these payers is better than none when it comes to minimizing the financial subsidization from public sector.

The model proposed here supports reimbursement within multiple payer systems when responsible payers (health plans) each pay for services at rates that support operations. Therefore, it is recommended that Alaska establish rates for their communities that can be applied to all. Otherwise, Alaska or local jurisdictions will be forced to cover the shortfall in payment from the responsible payers for care that is always available to all community members.

Crisis Service Coding

Establishing a common definition for “crisis services” is essential to this coding process given the ever expanding inclusion of the term “crisis” by entities describing offerings that do not truly function as “no-wrong-door” safety net services accepting all referrals. *Crisis Now* services are designed to connect individuals to care as quickly as possible through a systemic approach that is comparable to that of the physical health care system. The coding of crisis services must be standardized to support the sustainable reimbursement for these critical services. A brief description of these services and a straightforward strategy for coding in each case appears below:

Care Traffic Control Crisis Call Center Hub: This service represents the incorporation of a readily accessible crisis call center that is equipped to efficiently connect individuals in a BH crisis to needed care; including telehealth support services delivered by the crisis call center staff. Recognizing the provider's limited ability to verify insurance and identification over the phone, these services may be best funded as a safety net resource, but reimbursement for services delivered is an option. The most straight-forward option is to bill for services delivered to eligible individuals using the Healthcare Common Procedure Coding System (HCPCS) code of H0030 - Behavioral Health Hotline Service.

The limitation to the direct billing approach is that it can be very difficult to acquire adequate information to verify health care coverage and the identity of the service recipient during the phone interaction. However, some level of direct billing for care could be used to augment the funding received by Alaska state government that support operations. Crisis line providers do indeed deliver telehealth support to insured callers every day. Data elements such as member phone numbers of Medicaid enrolled or privately insured individuals can be combined with caller ID technology to support billing efforts.

There is another call center subsidization alternative for Alaska to consider. If there are periodic surveys of Careline callers to determine what percentage of callers are enrolled in Medicaid, then the costs associated with 50% of that percentage could potentially be applied under the 50% administrative FMAP under Medicaid.

Mobile Crisis Teams: Mobile crisis services represent community-based support where people in crisis are; either in the person's home or a location in the community. Services should be billed using the nationally recognized HCPCS code of H2011 Crisis Intervention Service per 15 Minutes. Limiting the use of this code to only community-based mobile crisis team services, positions a funder to set a reimbursement rate that represents the actual cost of delivering this safety net service much like a fire department of ambulance service reimbursement rate. When applicable, transportation services should be billed separately.

Crisis Observation and Stabilization Facilities: Crisis receiving and stabilization facility services are delivered by a 24/7 staffed multidisciplinary team that includes prescribers (psychiatrists and/or psychiatric nurse practitioners), nurses, clinicians and peers. Nationally recognized, the HCPCS codes of S9484 Crisis Intervention Mental Health Services per Hour and S9485 Crisis Intervention Mental Health Services per Diem, can be used to reimburse for services delivered. Medications, radiology, laboratory, CPT codes and professional evaluation and treatment services may be billed separately or bundled into reimbursement rates.

f. Administrative Services Organization (ASO) contract provisions that clearly articulate the role of the ASO relative to implementation and ongoing oversight of the crisis system.

The 1115 waiver mandated by SB 74 is intended to establish a network of BH services at the community and regional level to reduce the need for crisis-driven and urban-based emergency, acute, and residential care by supporting development of missing components of the care continuum.

As DHSS explained in the SB 74 fiscal notes, the statutory requirement to develop and manage an integrated BH program that uses evidence-based practices and improves accountability will be achieved through a contract with an Administrative Services Organization (ASO). The ASO will support all publicly funded BH services administered by the Department, including but not limited to the 1115 waiver services.

The ASO contract language remains unclear regarding what the exact role the ASO would assume in overseeing Alaska's crisis response system. Apparently, the State's Medicaid authority would initially be holding crisis service providers' contracts and would be paying their claims for the reimbursement of crisis services. Therefore, it will be challenging for the ASO to "support all publicly funded BH services administered by the Department," including crisis services during the implementation phase of the contract. It may be worthwhile for DBH to consider amending the ASO contract to clarify the ASO's specific responsibilities for the crisis response system in conformity with the *Crisis Now Model*.

At the local level, the respective boroughs should each designate an entity to be responsible for developing and monitoring the BH crisis system within its jurisdiction. Recommendations in this regard were delineated earlier under Recommendation 1 on page 46.

g. **Policies and regulations that allow and facilitate municipalities and boroughs to actively engage in the financing, development, and implementation of the *Crisis Now Model* in their respective jurisdictions.**

Some states have enacted authorizing legislation to establish BH authorities to plan, finance, and implement BH services, to include crisis services. These are sometimes organized as councils of government that allow for the regionalization of such authorities. In some instances, this authority also extends to participating in Medicaid to assist with the financing of BH services.

4. Safety Net Funding

There are still those who are uninsured and require safety net funding in order to access crisis services. In addition, crisis call centers and MCTs are not well supported by Medicaid or other payers, whether public or profit. Therefore, it is necessary for there to be additional financial supports to sustain Alaska's adoption of and ongoing support of the Crisis Now Model. The State of Alaska and the respective boroughs included within this Report, should explore all available financing options to sustain the proposed system.

Some states pass specific measures with allocations to provide social safety net funding to support the uninsured and to cover the cost associated with needs that are not included in health care benefits including Medicaid. The methods for accessing such funds is variable and often competitive. At the local level, where jurisdictions have levy authority, dedicated measures have been passed to better meet local BH needs. Often these funds have been intended to overcome local gaps in services and to fund services and programs that are not funded by Medicaid. Alaska and its communities are urged to seek similar financing measures.

5. Startup Costs

Without financial support for construction, equipment, and start-up costs associated with the establishment of new crisis stabilization facilities, it will be very challenging for providers to standup these facilities. Most providers do not have the assets necessary to assume these costs and therefore, without capital and initial financial operating assistance, these facilities will most likely not be established. Therefore, The State of Alaska, the respective boroughs included within this Report, and private foundations and hospitals, should partner and explore all available financing options to support the capital and initial operating costs to standup these new facilities.

Some states have capital allocations available for constructing and equipping facilities that serve to benefit the well-being of residents. The methods for accessing such funds is variable and often competitive. At the local level, where county and/or city governments have levy authority, dedicated measures have been passed to better meet local BH needs, including the construction of new facilities. Often these funds have been intended to overcome local gaps in services and to fund services and programs that are not funded by Medicaid. Alaska and its communities are urged to seek similar financing measures.

6. BH Workforce Development

Alaska is already challenged by a behavioral health workforce shortage which could end up being the final major barrier to achieving the goal of implementing the Crisis Now Model. Therefore, the Alaska Health Workforce Coalition should adopt BH workforce development as a priority and it should be adequately resourced to accomplish this aim.

Communities across the nation are challenged by a limited workforce to meet the needs of individuals with mental health and substance use needs. On the surface, the creation of a "no-wrong-door" set of crisis care services would seem to create greater demand for this already strained workforce. However, the implementation of *Crisis Now* actually reduces that demand by more efficiently deploying resources, connecting to care in real time in a manner that minimizes the time symptoms escalate, and the broader inclusion of peers within the system of care as a vital workforce resource with the potential to grow more quickly than others employed in BH care service delivery. Workforce needs are described for each component of the model as follows:

Care Traffic Control Crisis Call Center Hub Staffing

Crisis call center operations that incorporate air traffic control type functioning dramatically increase the efficiency of the overall system. Offerings such as GPS-enabled mobile team dispatch, real-time bed registry with coordination into care and outpatient appointment scheduling, all serve to decrease the volume of mobile teams and beds needed to meet the needs of the community. Crisis observation and stabilization centers that efficiently assess the needs of the individual and stabilize crisis episodes in less than half the time of traditional inpatient settings, further decreases the demand on beds that would otherwise need to be staffed. However, given BH workforce scarcity with the pent up demand for crisis services, Alaska should not expect a net BH workforce gain. In the implementation of a comprehensive crisis system, there typically is a decreased projected bed need capacity that does not always translate into the elimination of beds to the system as a whole. Employing peers support specialists throughout all of the Crisis Now service components does result in a net gain in BH practitioners.

Mobile Crisis Team Staffing

Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual. Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff. For example, a Master's- or Bachelor's-level clinician may be paired with a peer support specialist and the backup of psychiatrists or other master's-level clinicians who are typically accessed for on-call support as needed. Peer support specialists often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis. In this model, almost half of the mobile team system workforce will be filled by peers who are more broadly available than their licensed and/or credentialed clinician team partners.

Crisis Observation and Stabilization Facility Staffing

Crisis receiving and stabilization facilities must be staffed every hour of every day without exception so they will be equipped to accept any referral that comes to the program. To fulfill this commitment, programs must be staffed by a multidisciplinary team that includes the following:

- Psychiatrists or psychiatric nurse practitioners (telehealth may be used);
- Nurses;
- Licensed and/or credential clinicians capable of completing assessments in the region; and
- Peers with lived experience similar to those of the population served.

While the implementation of the *Crisis Now Model* does lessen the strains on the BH workforce, a far more comprehensive BH workforce strategy should be considered. Alaska has tended to be progressive in this regard, as evidenced by the Rural Psychology Internship Consortium which was developed in collaboration with the Western Interstate Commission on Higher Education (WICHE)

the Alaska Psychology Internship Consortium, the Alaska Health Workforce Coalition and loan repayment programs. It is recommended that the Alaska Health Workforce Coalition examine the New Mexico Health Care Workforce Committee which is tasked statutorily with surveying each of the state's professional licensing boards to determine by county, how many licensed health care professionals, including BH, are actually practicing versus serving in other capacities or perhaps living out of state or retired. The Committee issues an annual report to the state Legislature each October and the report provides a far more accurate assessment of practitioner capacity in the state, than simply relying on licensure data.

The 2019 Report: https://www.nmhanet.org/files/NMHCWF_2019Report_FINAL.pdf

By improving partnerships with Alaska's universities and professional schools, BH providers can assist with focusing academic endeavors to produce professionals that can better respond to the workforce demands of standing up new crisis programs.

7. Rural and Frontier Crisis Service Adaptations

Alaska is a very rural and frontier state. While Anchorage, Mat-Su, and Fairbanks are fairly densely populated and, as result, can support a comprehensive crisis continuum of care. The Crisis Now Model has not been developed to meet the crisis-related challenges within rural and frontier areas. Therefore, concurrent planning needs to occur in these areas to craft local and regional crisis solutions, using the Crisis Now Model framework as a guide.

The reality about BH care in rural America is complex. More than 60% of rural Americans live in mental health professional shortage areas, more than 90% of all psychologists and psychiatrists, and 80% of Masters of Social Work, work exclusively in metropolitan areas. More than 65% of rural Americans get their BH care from a primary healthcare provider, and the BH crisis responder for most rural Americans is a law enforcement officer. As a result of these BH workforce shortages in rural areas, comprehensive or specialty services are not typically available and choices regarding treatment options and provider types are extremely limited.

In addition to workforce challenges, accessibility is typically a significant barrier. Rural Americans travel further to get just about everything including BH care. But however difficult access is in the lower 48, it is further exacerbated in Alaska by its vast frontier where the only method for accessing services can be either boat or plane, weather permitting. To complicate matters further, rural Americans are less likely to recognize the symptoms of BH conditions and to know where to turn for help.

Alaska has had a home grown strategy for addressing some of these issues - the Community Health Aide Program using para-medics to provide primary care. This program is a partnership between the University of Alaska- Fairbanks and the Tribal Health Consortium. In more recent years, the program has expanded to include Community Behavioral Health Aides to provide BH care and support and to serve as extenders to BH professional staff in remote villages. This is a program

that could be further enhanced and applied to better address the BH needs of non-tribal Alaskans as well.

There have been other innovative rural intervention models previously in place in Alaska that might be worth reassessing. Other possible alternatives involve expanding the use of tele-psych services, Project Echo crisis training and consultation services, and Community Health Workers/Peer Support Providers. Seven states have implemented a methodology for licensed psychologists to become prescribing psychologists which would expand Alaska's capacity for the prescribing of psychotropic medication. Adding Psychologists as an approved independent provider of Medicaid services would also help address workforce challenges.

Commissioning another BH crisis system assessment initiative is warranted to better plan for meeting the BH crisis needs of those in rural and frontier Alaska and to assist in overcoming the barriers to accessing care. The assets and gaps that exist in rural Alaska must be carefully assessed, including the role of the tribal health system and bi-directional migration of tribal and non-tribal beneficiaries between rural communities, population centers, and how care is uniquely delivered and coordinated with input from tribal health providers of care.

8. Peer Workforce Development

Establish a plan and implement it for Alaska to train, credential, and develop an adult Peer Support Specialist credential that is a recognized BH provider type that is authorized to deliver peer support services and is paid, or reimbursed for services rendered, within the full array of healthcare and BH treatment and support settings, particularly those associated with delivering crisis services.

In the field of BH, Medicaid billing for peer support services began in Georgia in 1999, and quickly expanded nationally in 2007 after the Center for Medicare and Medicaid Services (CMS) sent guidelines to states on how to be reimbursed for services delivered by peer providers. In 2012, Georgia was approved as the first state to bill for a peer whole health and wellness service delivered by trained peer providers. CMS' Clarifying Guidance on Peer Services Policy from May 2013 states that any peer provider must "complete training and certification as defined by the state" before providing billable services; and beginning on January 1, 2014, CMS expanded the type of practitioners who can provide Medicaid prevention services beyond physicians and other licensed practitioners, at a state's discretion, which can include peer providers. Medicaid is the main payer for peer support services, although many state departments of BH offer grant funding for these services. Currently, 39 state Medicaid programs cover peer support services for either individuals with mental illness, individuals with addiction disorders, or both.

Some states have special provisions that allow them to only cover peer supports for limited groups of individuals, such as those enrolled in managed care. Some states also allow peer support specialists to act as qualified health care professionals for certain types of BH services, but do not allow for the specific reimbursement of peer support services. An examination of Medicaid fee-for-service reimbursement rates for selective states found a wide variation in reimbursement.

Group rates for a 15-minute period ranged from less than $2.00, to over $5.00, and individual rates ranged from $6.50 to $24.36 per 15 minutes. Comparatively, average peer specialist compensation was $15.42 in 2015 (see the *National Survey of Compensation among Peer Support Specialists*, The College for Behavioral Health Leadership, www.leaders4health.org , January, 2016).

Peer support services can be offered to Alaskans with either mental health conditions or substance use disorders. States may choose to deliver peer support services through several Medicaid funding authorities including the state plan rehabilitative services option, and Section 1915(b) or 1915(c) waivers. State Medicaid agencies have the authority to determine the service delivery system, medical necessity criteria, and the scope of peer support services. However, certain minimum service requirements must be addressed when states seek federal financial participation for peer support services:

- Supervision. Peer support service providers must be supervised by a competent mental health professional, as defined by the state. The amount, duration and scope of supervision may range from direct oversight to periodic care consultation.
- Care coordination. Peer support services must be coordinated within the context of an individualized plan of care. States should use a person-centered planning process that helps promote individual ownership of the plan of care. Plans of care must also include specific individualized goals that have measurable results.
- Training and credentialing. Peer support providers must obtain training and certification as defined by the state.
- The peer must demonstrate the ability to support the recovery of others from mental illness or SUDs.
- Ongoing continuing educational requirements for peer support providers must also be in place.

RI Provides the training and credentialing for 16 of the 39 states that have engaged peer support providers. In addition, RI is only second to the Department of Veterans Affairs in the number of peers that have been employed. Out of approximately 1100 employees, more than half are peer support providers. Should Alaska require assistance or guidance regarding the establishment and ongoing development of peer support services, RI is poised to be a resource to the State.

9. Crisis Call Center and Mobile Crisis Teams

Establish an Alaska Crisis and Access Line that is adequately resourced to operate statewide 24/7 as a fully functional Care Traffic Control Hub that dispatches tech-enabled MCTs across Anchorage, Mat-Su and Fairbanks; that possess real-time data on available crisis and psychiatric beds and outpatient BH treatment slots statewide; and provides text, chat, and peer-to-peer warm line services, also on a 24/7 basis.

It is recommended that the State consider enhancing and optimizing Careline to operate as its statewide wide crisis and access line, rather than starting from scratch. Careline can be further technologically developed to become a Care Traffic Control Crisis Call Center and all of its service

offerings can be expanded to be available 24/7. While the costs associated to accommodate adequate staffing, texting capability, and peer-to-peer warm line are not known, the total one-time set-up fee for the technology would be $424,500. There would also be a monthly subscription fee which would be tied to the volume of calls and MCT dispatches.

The innovative Crisis Resource Need Calculator offers an estimate of optimal crisis system resource allocations to meet the needs of a community as well as the impact on healthcare costs associated with incorporation of those resources. The calculator analyzes a multitude of factors that includes population size, average length of stay in various system beds, escalation rates into higher levels of care, readmission rates, bed occupancy rates and local costs for those resources. In communities in which these resources do not currently exist, figures from like communities can be used to support planning purposes.

The calculations are based on data gathered from several states and the Crisis Now Business Case video that explains the rationale behind the model can be seen on NASMHPD's www.crisisnow.com. Quality and availability of outpatient services also influences demand on a crisis system so the Crisis Resource Need Calculator should be viewed as a guide in the design process. True assessment of system adequacy must include a look at overall functioning of the existing system. Signs of insufficient resources will include, but are not limited to, psychiatric boarding in EDs and incarceration for misdemeanor offenses when connection to urgent care is the preferred intervention.

The Crisis Resource Need Calculator demonstrates the cost savings that can be realized by implementing mobile crisis and facility-based crisis services in a given community. Using the calculator, the population of the community is entered. If a given community was working to address the acute BH needs of individuals experiencing a crisis solely through inpatient care, the algorithms built into the Calculator will indicate that those with LOCUS level 5 scores, 68% of them would be referred to inpatient care. The Calculator would then project the exact number of psychiatric that would be required once the ALOS for the area is entered based on The Treatment Advocacy Center's published consensus estimate of needing 50 beds for every 100,000 members of the population.

The per diem inpatient rate for the area would also be entered which would tabulate as a total inpatient spend. After applying an ED cost for the area per admission to an inpatient bed (medical clearance and assessment), the total estimated cost escalates further. For the 32% of individuals with LOCUS levels scores of 1-4, no cost or service is included in the calculations, since in reality it is unlikely that any actual cost would be incurred. When MCT and facility-based crisis services are included in optimal ratios, total costs drop in the projections. This is despite engaging all of the appropriate LOCUS scored individuals. This means that the more individuals who are served with programs that align better to the unique level of clinical need, will result in lowered cost by a calculated percentage. Additionally, alignment of clinical level need to the service delivered improves from a low of 14% to as high as 100% in a *Crisis Now* system.

The algorithm also utilizes crisis key performance indicators from current community crisis providers to predict the capacity needed to adequately serve the expected number of crisis events that a community would experience over the course of a year. In utilizing this algorithm for Alaska, it is important to note that not all used data points came from current Alaska crisis providers. Alaska currently does not offer certain services whose data points would be used to inform the model. In these cases, the consultants used data points from high functioning crisis programs as a proxy, except in the case of Average Length of Stay for Crisis Observation Chairs and Short-term Crisis Beds. Based on the unique needs of Alaska, its large rural area and its lack of intensive community-based services, the RI Consultant Team have utilized an ALOS that is 33% higher than anticipated in communities that have stronger outpatient and post-crisis services.

Using the Crisis Resource Need Calculator, it is projected that the number of MCTs that are needed to service the three localities in question, are as follows:

- Anchorage – 2
- Mat-Su - 1
- Fairbanks - 1

With the co-responder team already operating at APD, the addition of two crisis MCTs would almost provide 24/7 coverage, but not for 7 days a week and on Holidays. These additional MCT staff could either be employees of Careline or of an Anchorage based BH provider organization. These additional MCTs could either be staffed during peak crisis periods and adjusted as utilization patterns change, or the appropriate funders at the State and local level could decide to support an additional MCT to assure 24/7 availability each day of the week and to compensate for time-off and Holidays by the staff of the three primary MCTs.

The population density of both Mat-Su and Fairbanks do not justify more than a single MCT. Obviously, this is insufficient to provide 24/7 coverage. Therefore, it would make sense for Careline to be somewhat over-staffed during peak call-in periods so that two staff could be redeployed to become the MCT for Fairbanks. Careline has call capacity back-up available to compensate for heightened call volume while the MCT is deployed. While this is not the ideal, it does provide a MCT resource until such time as the mobile response utilization metrics justify the establishment of an additional MCT.

In Mat-Su the options are less clear. The team in this community might be comprised of individuals who are employed at the new Mat-Su Regional Medical Center's new psychiatric ED and inpatient BH unit who are redeployed when necessary, particularly until full utilization and occupancy is established. Or perhaps, this MCT is comprised of contingent independent BH contractors who are on-call 24/7 to perform this function. These are considerations a local BH Crisis Services Steering Committee may contemplate to determine needs specific to Mat-Su.

10. Crisis Response Centers

Establish regional Crisis Response Centers that operate as high acuity levels of care under the "no wrong door" approach, admitting all those who present, whether voluntarily or involuntarily in accordance with the Crisis Now Model to include:

a. **A 23-hour crisis stabilization/observation unit that uses recliners instead of beds to maximize capacity flexibility, client flow, and create an environment conducive to dialog during the initial crisis engagement period. This component acts as a "psychiatric emergency department" and accepts a large percentage of its admissions as diversions from jails and EDs.**

b. **A 16-bed short-term non-IMD facility with crisis beds, licensed as residential, sub-acute and/or hospital beds depending on state licensure requirements. These units are intended to serve approximately 30% of the admissions that are not stabilized in the 23-hour observation unit during the first day with an average length of stay between 2.5 and 3 days.**

Again using the Crisis Resource Need Calculator, it is projected that the number of recliners for a 23 hour Crisis Observation Center and the number of beds for a Stabilization Center that are needed to service the three localities in question, are as follows:

- Anchorage – 13 recliners and 19 beds
- Mat-Su - 6 recliners and 9 beds
- Fairbanks - 4 recliners and 7 beds

Anchorage has sufficient crisis service need volume to justify establishing a Crisis Response Center with at least 13 recliners for the 23 hour crisis observation center and at a minimum 16 crisis stabilization beds for the crisis stabilization center. Both of these services should be co-located under one roof, which would maximize the flexibility necessary for both client flow and staffing. As other crisis service alternatives are made available, Anchorage would be well on its way to creating a Campus of Connection that might include supplemental crisis service alternatives and other treatment and social service options as deemed appropriate. When the IMD exclusion for mental health services is waived, Anchorage would be free to add additional beds and should plan its Crisis Response Center accordingly.

Given the plans of Mat-Su Regional Medical Center to create new inpatient behavioral Health bed capacity in January of 2020, it will be critical to re-evaluate how the additional beds impact the community. It is likely the community will still need a crisis stabilization center with approximately 6 23-hour observation recliners and 9 short term crisis stabilization beds, however a feasibility study will need to be conducted to further examine capacity needs for these levels of care with the new beds coming on line.

Fairbanks, on the other hand, is more challenging as it doesn't appear to have the projected volume necessary to support the costs associated with operating at 24/7 capacity. Given this reality,

Fairbanks might consider starting with 16 bed crisis stabilization center which is slightly more capacity than that required for both an observation and stabilization center. Since the short stays for crisis observation and since longer ALOS is anticipated for Alaska, 16 beds should be close to occupancy most of the time. When the stabilization center eventually reached capacity, a crisis observation center with recliners can be added.

11. Cost Offsets and Reinvestment Opportunities

Once the components of *Crisis Now Model* are implemented, an analysis of the resulting cost offsets should be made associated with the reductions in detention, ED, and hospital utilization; and plans developed and implemented for the reinvestment of those savings to further buildout additional enhancements to the crisis system and to the BH continuum of care to better provide intensive levels of community-based care and to better address the social determinants of health.

As noted previously, essential crisis system elements are limited to (1) the crisis call center hub, (2) crisis mobile response and (3) crisis receiving and stabilization services. A multitude of other resources that support a comprehensive system of care exist; including facility-based resources such as short-term residential facilities and peer respite programs that often step down options for individuals following a crisis episode.

Short-Term Residential Facilities

After reviewing prior reports and research and considering presentations on model programs, RI has found that small, home-like short-term residential facilities can be seen as a strong step-down option to support individuals who do not require inpatient care after their crisis episode. In many communities, these are called crisis residential facilities. SAMHSA cautions that these are not actual crisis facilities given the criteria that a crisis facility must accept all referrals without a pre-screening process. However, they are an important part of a continuum that can used to address the needs of individuals experiencing LOCUS assessed needs of 4 and 5 in a cost effective manner. As such, staffing for these programs is far less intensive than a crisis receiving and stabilization facility. Short-term crisis residential programs should minimally have a licensed and/or credentialed clinician on location for several hours each day and on-call for other hours.

To maximize their usefulness, short-term residential facilities should function as part of an integrated regional system of care. Access to these programs should be facilitated through the air traffic control (ATC)-capable call center hub to maximize system efficiency. This approach also centralizes data regarding program occupancy, lengths of stay, percentage of referrals accepted and time to make decisions on referral acceptance; offer valuable data on how each participate in the system of care is supporting the needs of the community.

Peer-Operated Respite

Another model of short-term facility-based care is a peer-operated respite program. These programs do not typically incorporate licensed staff members on site although some may be involved to support assessments. They provide peer-staffed, restful, voluntary sanctuary for people in crisis, which is preferred by guests and increasingly valued in service systems. Peer-respite offers a low-cost, supportive step-down environment for individuals coming out of or working to avoid the occurrence of a crisis episode. Program activities should focus on issues that have contributed to the escalation in challenges facing the individual and/or their support system and the skills need to succeed in the community.

Other Options

There are a host of other alternative services that are worthy of consideration by the State of Alaska that involve not only providing more community-based intensive treatment services such as Assertive Community Treatment (ACT) and Medication Assisted Treatment (MAT) to support those with chronic BH conditions to sustain recovery and to minimize the risks for ED utilization, hospital readmissions, arrest, and detention, but also to address the social determinants of health, such a Permanent Supportive Housing (PSH), and Supported Education and Employment services. Ultimately, Alaska like every other state must get upstream to prevent BH conditions and their effects in the first place, rather than always having to pay exorbitant costs on the back end to intervene to treat these conditions. Therefore, it is urged that there be greater investments in primary prevention, such as the highly researched and evidence-based, PAX Good Behavior Game.

12. Tribal Health Coordination of Care

Establish coordination of crisis care agreements with the appropriate Tribal Health entities to ensure that Alaska Native and American Indian people in need of such care, have no disruptions in continuity of care when transitioning from one service system to another.

Crisis services should not be viewed as stand-alone resources operating independently of the BH, health, social services, and criminal justice systems operating in a given locality, but instead integrated into a coordinated continuum of care. Services needs and preferences of the individual served must be assessed to inform the interventions of the crisis provider and the connections to care that follow the crisis episode. This is not easily achieved given the complex dynamics that are in play in most communities that have complex service system ecosystems that can serve impediments to the care of any given individual and/or family. Given that the linkages of a continuum of care will not typically align, a purposeful intent, regular communication, negotiated agreements governing care coordination, and the development and utilization of data tools to measure the effectiveness of such agreements, and their impact on those served, become paramount. As stated earlier in this Report, the Alaskan implementation of the Emergency Department Information Exchange (EDIE) provides the State with a leg up in this regard. It can be used not only in Anchorage, Mat-Su and Fairbanks, but statewide to assure that care coordination occurs in real time.

According to the Office of the Commissioner of the Alaska Department of Health and Social Services, nearly 40% of Medicaid clients are Alaska Native people and an equal amount of program expenditures are made on their behalf. Alaska Native people are more likely to utilize health care services provided by the tribal health system, if available. However, two thirds of the funds spent on Alaska Native health care is paid to private sector providers. Given these realities, it is critical that when BH crisis services are accessed outside the tribal health system that care coordination protocols and agreements be negotiated so that adequate and appropriate care coordination can occur. And, to ensure the state can receive the 100% FMAP. Likewise, it is critical that as Alaska builds out its crisis response system, that it explores partnerships between providers, health systems (tribal and non-tribal), payers and agencies to determine how this crisis response system can best serve Alaskans. As the *Crisis Now Model* is implemented for the more urban settings, the tribal health system might further explore how and to what degree the adoption of the *Crisis Now Model* could potentially be of service to its beneficiaries statewide.

13. Commercial Insurance Parity

The inherent inequities in the benefit structures of commercial health plans to financially support crisis care should be examined as a parity issue and addressed within Alaska's insurance regulatory structure.

Establishing universally recognized and accepting coding for crisis services is an essential step towards delivering the promise of parity under the Affordable Care Act and is intended to move BH out of the shadows and into mainstream care of the whole person. For individuals experiencing a BH crisis, access to timely and effective care must be equivalent to that of a person with a physical health emergency. Unfortunately, access to effective care during a BH crisis is widely known to be deficient in healthcare settings across the country and too often, third-party payers including Medicare fall short in paying for BH crisis services. "*8 in 10 ED Doctors Say Mental Health System Is Not Working for Patients*" according to a survey by the American College of Emergency Physicians (ACEP). Thousands of Americans are dying from suicide every month, many family members of those coping with serious mental illness or loss of loved ones to suicide are experiencing unspeakable pain, individuals with limited options are getting the wrong care in the wrong place with jails, EDs and inpatient care substituting for BH services and law enforcement functioning as de facto MCTs; and jails as de facto treatment centers.

According to the 2019 published *Road Runner Study* by the Treatment Advocacy Center, more than $17.7 million was spent in 2017 by reporting law enforcement agencies which transported people with severe mental illness. If extrapolated to law enforcement agencies nationwide, this number is approximately $918 million or 10% of law enforcement's annual operating budget. Additionally, mental illness is the most prevalent disability in the United States. The time is now to solidify better access to crisis care and change these unacceptable outcomes that are adversely impacting our communities, filling our jails and crowding emergency departments. A nationally recognized framework for delivering a full continuum of crisis care has been established by the National Action Alliance for Suicide Prevention Crisis Services Task Force with resources found on the National

Association of State Mental Health Program Director's (NASMHPD's) www.crisisnow.com website and healthcare coding is available to support reimbursement for care.

14. Crisis Judicial Ruling

A judicial ruling has recently been made in a lawsuit filed a year ago by the Disability Law Center of Alaska and the Public Defender Agency seeking the cessation of lengthy jail and emergency room detentions of people in a mental health crisis. The ruling orders the Alaska Department of Health and Social Services to submit a plan for appropriate dispositions in these cases. Alaska should use the implementation of the Crisis Now Model as a major component of that plan, particularly for higher population urban communities.

The *Crisis Now Model* offers a major diversion from detention and from the lengthy onboarding in EDs. In Maricopa County Arizona where the *Crisis Now Model* is utilized with the highest fidelity in the nation, the decreased reliance on law enforcement as BH providers of last resort yield considerable saving to local law enforcement agencies. Maricopa County saved the equivalent of 37 FTE law enforcement officers as a result of effective diversion away from officer response and decreased time on scene when involved in a BH situation. When combined with appropriate screening, assessment, and BH treatment while incarcerated, and with meaningful reentry services, the Criminal Justice Reinvestment Initiative of the Council of State Governments has demonstrated that recidivism can be reduced to 5%, if reoffending has been prevented during the three years subsequent to release.

Appendix A: Core Principles and Practices of Crisis Now

There are several additional elements that must be systematically "baked into" excellent crisis systems in addition to the core structural elements that are essential for modern crisis systems (ATC capabilities, MCTs, and crisis residential facilities). These essential principles and practices are:

- Embracing recovery
- Significant role for peers
- Trauma-informed care
- Suicide safer care
- Safety/security for staff and consumers
- Crisis response partnerships with law enforcement

Embracing Recovery

Crisis providers must embrace the reality that individuals and families move beyond their BH challenges to lead happy, productive and connected lives each and every day. At the 2019 International Initiative for Mental Health Leadership (IIMHL) Crisis Now Summit, consumer Misha Kessler ended his description of his direct experiences with crisis services, "Mental illness is [just] one part of my tapestry." The fact that recovery is possible and that it means not just the absence of symptoms, but also the development of meaning and purpose in life, has begun to transform mental health care (Anthony, 1993). The President's New Freedom Commission on Mental Health (Hogan, 2003) recommended that mental health care be "recovery-oriented" and enriched by person-centered approaches, a hopeful and empowering style, and increased availability of support by individuals with lived experience.

The significance of a recovery-oriented approach is critical for those in crisis, and thus for crisis settings. In an outmoded, traditional model, crises typically reflect "something wrong" with the individual. Risk is seen as something to be contained, often by means of an involuntary commitment to an inpatient psychiatric unit. In worst-case scenarios, people end up restrained on emergency room gurneys or in jails. These actions in turn, are traumatizing to those who are subjected to them, and they also further reinforces the likelihood that the person will soon again recycle through this same revolving door of inadequate crisis interventions.

In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are managed in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one's own recovery and ability to respond effectively to future crises. The recovery-oriented approach to crisis care is integral to transforming a broken system.

Implementation Guidance

1. *Commit to a "no force first" approach regarding care that is characterized by engagement and collaboration;*
2. *Create engaging and supportive environments that are as free of barriers as possible. This would include eliminating Plexiglas from crisis stabilization units and minimal barriers between team members and those being served in order to support stronger connections;*
3. *Ensure team members engage individuals in the care process during a crisis. Communicate clearly to those in care regarding all treatment and intervention options, and offer materials regarding any processes in writing, in the individual's preferred language whenever possible;*
4. *Ask the individual served about their preferences and do what can be done to align any actions to those preferences; and*
5. *Work to convert those with an involuntary commitment to voluntary as soon as practicable, so they become more invested in their own well-being and recovery.*

Significant Role for Peers

One specific, transformative element of recovery-oriented care is to fully engage the experience, capabilities, and compassion of those who have experienced BH crises. Integrating those "with lived experience" within the components of crisis care has repeatedly demonstrated that they "take all of [their] experiences, regardless of the pain, and use them to transform [their] life into 'living hope' for others who want to recover" (Ashcraft, Zeeb, & Martin, 2007). This reality has been increasingly substantiated by studies investigating peer services and supports. This body of work has found support for a range of peer support benefits including strengthened hope, relationship, recovery, and self-advocacy skills and improved community living skills (Landers & Zhou, 2011).

Utilizing peers, especially those who have experienced suicidality and suicide attempts, and learned from these experiences, can provide a safe, authentic, and respectful context within which the feelings of aloneness and burdensomeness, associated with suicidality, can be permeated. Peer intervention in the crisis setting with suicidal individuals is particularly potent in light of the reported 11%-50% range of attempters who refuse outpatient treatment or abandon outpatient treatment quickly following an ED referral (Kessler et al., 2005). Peers support specialists can relate without judgment, can communicate hope in a time of great distress, and can model the fact that improvement and success are possible. This increases engagement while reducing distress.

The role of peers—specifically survivors of suicide attempts, as well as, survivors of suicide loss—was bolstered when the Action Alliance's Suicide Attempt Survivors Task Force released its groundbreaking report, The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience, in July 2014. The report describes the many ways in which learning from and capitalizing on lived experience can be accomplished.

Implementation Guidance

1. *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible; including, but not limited to, gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age considerations;*
2. *Develop support and supervision that aligns with the needs of the program's peer staff; and*
3. *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program. This would include peers who:*
   a. Are available for connection with crisis line operations;
   b. Serve as one of two mobile team members; and
   c. Are one of the first individuals to greet someone upon entrance to a crisis stabilization facility.

Trauma-Informed Care

The great majority of individuals served with BH services have experienced significant interpersonal trauma. The adverse effects of child trauma may present well into adulthood, increasing the risk for post-traumatic stress disorder (PTSD), mental illness, substance use, and poor medical health (Finkelhor et al., 2005). Persons with a history of trauma or trauma exposure are more likely to engage in self-harm and suicide attempts and their trauma experiences make them acutely sensitive to how care is provided to them. When crisis care involves a loss of freedom, noisy and crowded environments, and/or the use of force, there is an exacerbation of presenting symptoms. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened increased agitation or withdrawal, and often followed a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calming can facilitate stabilization and healing. Therefore, trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA posited five guiding principles for trauma-informed care:

1. Safety
2. Trustworthiness and transparency
3. Peer Support and mutual self-help
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical and gender issues

These principles should inform treatment and recovery services. When these principles are applied to practice, they become self-evident to staff, clients, and their significant others. The program's culture becomes transformed. All clients are screened for trauma exposure and its impact on overall well-being. Addressing the trauma that family and significant others have experienced is also a critical component that assists stabilization and reduces the possibility for further trauma or crisis.

Developing and maintaining a healthy treatment and support environment also requires support for staff, who may have a trauma history or may experience post-secondary trauma as a result of working with other trauma victims. An established resource for further understanding trauma-informed care is provided by SAMHSA (2014): Trauma-Informed Care in Behavioral Health Services (TIP 57). Trauma-informed care is urgently important in crisis settings because of the links between trauma and crisis and the vulnerability of people in crisis; especially those with trauma histories.

Implementation Guidance

1. *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed; and*
2. *Apply assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program and create action steps based on those assessments.*

Suicide Prevention

Crisis intervention programs have always focused on suicide prevention. This stands in contrast to other health care and mental health services, where suicide prevention was not always positioned as a core responsibility. Two transformational commitments must be made by every crisis provider in the nation: (1) adoption of suicide prevention as a core responsibility, and (2) commitment to dramatic reductions in suicide among people under care. These changes were adopted and advanced in the revised National Strategy for Suicide Prevention (2012), specifically via a new Goal 8: "Promote suicide prevention as a core component of health care services."

The National Action Alliance for Suicide Prevention created a set of evidence-based actions known as Zero Suicide or Suicide Safer Care that health care organizations can apply through an implementation toolkit developed by the Suicide Prevention Resource Center (SPRC) at the Education Development Center, Inc. (EDC). The following seven key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

- Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, which includes survivors of suicide attempts and suicide loss in leadership and planning roles;
- Develop a competent, confident, and caring work force;
- Systematically identify and assess suicide risk among people receiving care;
- Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs and that includes collaborative safety planning and reducing access to lethal means;
- Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors; Provide continuous contact and support, especially after acute care; and
- Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

See more at http://zerosuicide.sprc.org/about

It should be noted that the elements of zero suicide closely mirror the standards and guidelines of the National Suicide Prevention Lifeline (NSPL), which has established suicide risk assessment standards, guidelines for callers at imminent risk, protocols for follow-up contact after the crisis encounter, and has promoted collaborative safety planning, reducing access to lethal means, and incorporating the feedback of suicide loss and suicide attempt survivors.

Since comprehensive crisis intervention systems are the most urgently important clinical service for suicide prevention and most parts of the country do not have adequate crisis care, we find a national- and state-level commitment to implementing comprehensive crisis services is foundational to suicide prevention; leading to an expectation that best practices in suicide care by required by health authorities (i.e., payers, plans, state agencies, Medicaid and Medicare).

Implementation Guidance

1. *Incorporate suicide risk screening, assessment and planning into the new employee orientation for all team members;*
2. *Assign the completion of Applied Suicide Intervention Services Training (ASIST) or similar training to all team members;*
3. *Incorporate suicide risk screening, assessment and planning into the crisis practices;*
4. *Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic medical record; and*
5. *Commit to a goal of Zero Suicide as a state and as a crisis system of care.*

Safety/Security for Consumers and Staff

Safety for both consumers and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality, an issue with life and death consequences. While ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised.

People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been brought in by law enforcement and thus may present an elevated risk for violence.

Trauma-informed and recovery-oriented care is safe care. But much more than philosophy is involved. DHHS's Mental Health Crisis Service Standards (2006) begin to address this issue, setting parameters for crisis services that are flexible and delivered in the least restrictive available setting while attending to intervention, de-escalation and stabilization.

Keys to safety and security in crisis delivery settings include:

- Evidence-based crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;

- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent;
- Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures;
- Pre-established criteria for crisis system entry; and
- Strong relationships with law enforcement and first responders.

Ongoing staff training is critical for maintaining both staff competence and confidence, and promotes improved outcomes for persons served and decreased risk for staff (Technical Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and clients in the crisis setting.

Adequate staffing for the number and clinical needs of consumers under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers and peer support professionals) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to self or others (DHHS, 2006).

In some crisis facilities that are licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both clients and staff and may re-traumatize individuals who have experienced physical trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as a threat of punishment, alternative to appropriate staffing of crisis programs, as a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

Crisis providers must engage in person-centered planning and treatment while assessing risk for violence to collaboratively develop de-escalation and safety plans for individuals served by the program. Debrief staff and individuals involved in those interventions after a seclusion/restraint event to inform policies, procedures, and practices; reducing the probability of future use of such interventions.

Following the tragic death of Washington State social worker Marty Smith in 2006, the Mental Health Division of the Department of Social and Health Services sponsored two safety summits. The legislature passed into law a bill (SHB 1456) relating to home visits by mental health professionals.

According to Washington's SHB 1456, the keys to safety and security for home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone;

- Employers will equip mental health workers who engage in home visits with a communication device; and
- Mental health workers dispatched on crisis outreach visits will have prompt access to any history of dangerousness or potential dangerousness on the client they are visiting, if available.

Ensuring safety for both consumers and staff is the very foundation of effective crisis care. While safety is urgently important in all health care, in crisis care, the perception of safety is also essential. The prominence and damaging effects of trauma and the fear that usually accompanies a psychological crisis.

Implementation Guidance

1. Commit to a "no force first" approach to care;
2. Monitor, report and review all incidents of seclusion and restraint with a goal to minimize the use of these interventions;
3. Barriers do not equal safety. The key to safety is engagement and the empowerment of the individual served while in crisis;
4. Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all;
5. Incorporate quiet spaces into the crisis facility for those who would benefit from time away from the milieu of the main stabilization area; and
6. Engage team members and those served in discussions regarding how to enhance safety within the crisis program, make safety truly "Job One" in all crisis settings.

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with BH conditions in recent years. Some involvement with BH crises is inevitable for police. As first responders, they are often the principal point of entry into emergency care for individuals experiencing a BH crisis.

Police officers are critical to mobile crisis services as well; by either providing support in potentially dangerous situations (Geller, Fisher, & McDermeit, 1995); or by serving as a referral source delivering "warm hand-offs" to crisis mobile teams. Research investigating law enforcement response to individuals with mental illness (Reuland, Schwarzfeld, & Draper, 2009) found police officers frequently:

- Encounter persons with mental illness at risk of harming themselves;
- Often spend a greater amount of time attempting to resolve situations involving people exhibiting mental health concerns;
- Address many incidents informally by talking to the individuals with mental illness;
- Encounter a small subset of "repeat players"; and
- Often transport individuals to an emergency medical facility where they may wait for extended periods of time for medical clearance or admission.

In many communities across the United States, the absence of sufficient and well-integrated BH crisis care has made local law enforcement the de facto BH mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement to address emergent public safety risk is essential and important. With good BH crisis care in place, MCTs can collaborate with law enforcement which will improve both public safety and produce better outcomes for those in crisis. Unfortunately, well intentioned law enforcement responders to a crisis call can often escalate the situation just based on their presence. Police vehicles and armed officers can generate anxiety for far too many individuals in a crisis.

We now know a good deal about crisis care/law enforcement collaboration. Deane et al. (1999), reporting on partnerships between BH personnel and law enforcement, found the alliance between first responders and BH professionals helped to reduce unnecessary hospitalization or incarceration. Specialized responses to BH crises included specialized police response, police-based specialized BH response, and BH-based specialized BH response. These forms of collaboration share the common goal of diverting people with BH crises from criminal justice settings into BH treatment settings and were rated as "moderately effective" or "very effective" in addressing the needs of persons in crisis.

Specialized police responses involve police training by BH professionals in order to provide crisis intervention and to act as liaisons to the BH crisis system. The Memphis Crisis Intervention Team (CIT) model pioneered this approach. In CIT, training for law enforcement includes educating officers about mental illness, substance use and abuse, psychiatric medications, and strategies for identifying and responding to a crisis (Tucker et al., 2008). Lord et al. (2011) found most officers involved volunteered to participate in the training.

Consistent with the findings above, CIT necessitates a strong partnership and close collaboration between the police officers and BH programs (e.g., availability of a crisis setting where police can drop off people experiencing a mental health crisis). CIT has been cited as a "Best Practice" model for law enforcement (Thompson & Borum, 2006). Crisis programs should engage in ongoing dialog with local law enforcement agencies to support continuous quality improvement and collaborative problem solving. Top crisis systems report facilitating monthly meetings with aggregate data sharing as a part of their ongoing operations.

Strong partnerships between BH crisis care systems and law enforcement are essential for public safety, suicide prevention, connections to care justice system diversion and the elimination of psychiatric boarding in emergency departments. The absence of a comprehensive crisis system has been the major "front line" cause of the criminalization of those with BH conditions, and a root cause of shootings and other incidents that have left too many people with such conditions and police officers dead. Collaboration is the key to reversing these unacceptable trends.

Implementation Guidance

1. *Have local crisis providers actively participate in CIT training sessions;*
2. *Incorporate regular meetings between law enforcement and crisis providers into the schedule so that these partners can work to continuously improve their practices;*
3. *Include BH crisis provider and law enforcement partnerships in the training for both partner groups; and*

4. *Share aggregate outcomes data, such as: numbers served, percentage stabilized and returned to the community, and connections to ongoing care.*

Crisis Service Best Practice Fidelity Review Tool

SAMHSA is about to publish a *Crisis Service Best Practice Fidelity Review Tool*. The Fidelity Review Tool is designed to assist in the implementation of essential crisis service elements, and to assist with the delineation of performance expectations. These elements are summarized below:

1. Regional or statewide crisis call centers coordinating in real time:
   a. Operate every moment of every day (24/7/365);
   b. Staff with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
   c. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center standards defined in this toolkit;
   d. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;
   e. Coordinate connections to crisis mobile team services in the region;
   f. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed;
   g. Incorporate caller ID functioning;
   h. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
   i. Implement real-time regional bed registry technology to support efficient connection to needed resources; and
   j. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.
2. Centrally deployed, 24/7 mobile crisis:
   a. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;
   b. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times;
   c. Connect individuals to facility-based care through warm hand-offs and coordinating transportation as needed;
   d. Incorporate peers within the mobile crisis team;
   e. Respond without law enforcement accompaniment unless special circumstances warrant inclusion; supporting true justice system diversion;
   f. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; and
   g. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care.
3. 23-hour crisis observation and stabilization facilities:
   a. Accept all referrals without pre-screening;

b. Do not require medical clearance prior to admission but will assess for and support medical stability while in the program;
c. Design their services to address mental health and substance use crisis issues;
d. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges:
e. Staff at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
    i. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
    ii. Nurses
    iii. Licensed and/or credential clinicians capable of completing assessments in the region; and
    iv. Peers with lived experience similar to those of the population served.
f. Offer walk-in and first responder drop-off options;
g. Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no reject policy for first responders;
h. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated;
i. Function as a 24 hour or less crisis receiving and stabilization facility;
j. Offer a dedicated first responder drop-off area;
k. Incorporate some form of intensive support beds into a partner program (could be own program or another provider) to support flow for individuals who need additional support;
l. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; and
m. Coordinate connection to ongoing care.

In addition to monitoring fidelity to the Crisis Service Best Practice Standards, funders, system administrators and crisis service providers should continuously evaluate performance through the use of shared data systems. System transparency and the regular monitoring of key performance indicators supports continuous quality improvement. It is highly recommended that systems apply shared systems that offer real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches that focus on value. Performance metrics include the following:

- Crisis Call Center Services:

    - Call volume,
    - Average speed of answer,
    - Average delay,
    - Average length of call,
    - Call abandonment rate (should be very low),
    - Percentage of calls resolved by phone (should be over 90%),
    - Number of mobile teams dispatched,
    - Number of individuals connected to a crisis or hospital bed, and
    - Number of first responder-initiated calls connected to care.

- Crisis Mobile Services:

  - Number served per 8-hour shift,
  - Average response time,
  - Percentage of calls responded to within 1 hour… 2 hours,
  - Longest response time, and
  - Percentage of mobile crisis responses resolved in the community (should be around 70% - hospital / crisis facility diversion)

- Crisis Observation and Stabilization Facilities:

  - Number served (could be per chair daily),
  - Percentage of referrals accepted (should be 100%),
  - Percentage of referrals from law enforcement (should be substantial – hospital and jail diversion),
  - Law enforcement drop-off time (should be under 5 minutes because all referrals are accepted),
  - Percentage of referrals from all first responders (including law enforcement – hospital and jail diversion),
  - Average length of stay (throughput matters – support increased capacity within a limited resource),
  - Percentage discharge to the community (target high percentage of crisis resolved and transition back home – hospital diversion),
  - Percentage of involuntary commitment referrals converted to voluntary (this is 75% in Maricopa County in support of diversion from longer inpatient stays and individual engagement in care),
  - Percentage not referred to emergency department for medical issues / assessment (should target over 95% to divert from ED costs and boarding),
  - Readmission rate,
  - Percentage completing an outpatient follow-up visit after discharge,
  - Total cost of care for crisis episode,
  - Guest service satisfaction, and
  - Percentage of individuals reporting improvement in ability to manage future crisis.

Appendix B: Anchorage Capacity Model Calculator

Crisis System Needs Analysis - Anchorage		
	Baseline	**Optimized**
# of Crisis Episodes Annually (200/100,000 Monthly)	**6,997**	**6,997**
"Needed" Acute Beds for Population	*116*	*40*
Number of Acute Hospital Bed Days Needed Per Year	*42,277*	*12,013.93*
ALOS	*8*	*8*
Acute Inpatient Readmission Rate	*15%*	*15%*
Acute Bed Occupancy Rate	90%	90%
% Initially Served by Acute Inpatient	68%	14%
Number Initially Served by Acute Inpatient	4,756	961
Number Referred to Acute Inpatient From Crisis Facility	-	391
Number of Acute Inpatient Beds Needed	**116**	**40**
Cost Per Acute Inpatient Bed Per Day	$ 1,456	$ 1,456
Total Cost of Acute Inpatient Beds	**$ 61,554,685**	**$ 21,257,600**
Total Number of Episodes in Acute Inpatient	4,756	1,352
Diversion Rate of Crisis Facility (From Acute)	75%	75%
ALOS of Crisis Subacute Bed	4.0	4.0
Crisis Facility Readmission Rate	*15%*	*15%*
Difference Between Crisis and Acute Readmission Rates	0%	0%
% Initially Served by Crisis Subacute Bed	0%	0%
Number Initially Served by Crisis Subacute Bed	-	-
Number Referred to Crisis Subacute Bed by Obs Chair	-	1,564
Crisis Subacute Bed Occupancy Rate	90%	90%
Number of Crisis Subacute Beds Needed	**-**	**23**
Avg. Cost Per Crisis Subacute Bed Per Day	$ 1,456	$ 1,456
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 12,223,120**
Rate of Escalation to Subacute Bed	35%	35%
ALOS in Observation Chair	0.9	0.9
% Initially Served by Crisis Obs Facility	0%	54%
Number Initially Served by Crisis Facility	-	3,795
Number Referred to Crisis Facility by Mobile Team	-	672
Crisis Bed Occupancy Rate	85%	85%
Number of Crisis Observation Chairs Needed	**-**	**16**
Avg. Cost Per Crisis Bed / Chair Per Day	$ 1,820	$ 1,820
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 10,628,800**
Total Number of Episodes in Crisis Facility	-	4,468

Crisis System Needs Analysis - Anchorage (continued)		
Diversion Rate of Mobile Team (From Crisis Facility)	70%	70%
% Served by Mobile Team	0%	32%
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	-	**2**
Cost Per Mobile Team	$ 300,000	$ 300,000
Total Cost of Mobile Teams	**$ -**	**$ 644,613**
Total Number of Episodes with Mobile Team	-	2,241
TOTAL Unique Number of Individuals Served	**4,756**	**6,997**
TOTAL Unique Number of MT / Crisis / Acute Episodes	**4,756**	**8,060**
TOTAL Inpatient and Crisis Cost	**$ 61,554,685**	**$ 44,754,133**
Change in Cost	**0%**	**-27%**
ED Costs (35% of Initial Acute with ED Estimate)	**$ 3,768,745**	**$ 1,087,448**
TOTAL Cost	**$ 65,323,429**	**$ 45,841,581**
TOTAL Change in Cost	**$ (19,481,848)**	**-30%**
NOTES	**Crisis Savings**	**$ 16,800,551**
	Total Savings	**$ 19,481,848**
Pharmacy not included		
35% of direct acute admissions go to ED first at $2,264		

Appendix C: Mat-Su Capacity Model Calculator

Crisis System Needs Analysis - Mat-Su		
	Baseline	**Optimized**
# of Crisis Episodes Annually (200/100,000 Monthly)	**2,583**	**2,583**
"Needed" Acute Beds for Population	*43*	*15*
Number of Acute Hospital Bed Days Needed Per Year	*15,605*	*4,434.48*
ALOS	*8*	*8*
Acute Inpatient Readmission Rate	*15%*	*15%*
Acute Bed Occupancy Rate	90%	90%
% Initially Served by Acute Inpatient	68%	14%
Number Initially Served by Acute Inpatient	1,756	355
Number Referred to Acute Inpatient From Crisis Facility	-	144
Number of Acute Inpatient Beds Needed	**43**	**15**
Cost Per Acute Inpatient Bed Per Day	$ 1,456	$ 1,456
Total Cost of Acute Inpatient Beds	**$ 22,720,536**	**$ 7,971,600**
Total Number of Episodes in Acute Inpatient	1,756	499
Diversion Rate of Crisis Facility (From Acute)	75%	75%
ALOS of Crisis Subacute Bed	4.0	4.0
Crisis Facility Readmission Rate	*15%*	*15%*
Difference Between Crisis and Acute Readmission Rates	0%	0%
% Initially Served by Crisis Subacute Bed	0%	0%
Number Initially Served by Crisis Subacute Bed	-	-
Number Referred to Crisis Subacute Bed by Obs Chair	-	577
Crisis Subacute Bed Occupancy Rate	90%	90%
Number of Crisis Subacute Beds Needed	**-**	**9**
Avg. Cost Per Crisis Subacute Bed Per Day	$ 1,456	$ 1,456
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 4,782,960**
Rate of Escalation to Subacute Bed	35%	35%
ALOS in Observation Chair	0.9	0.9
% Initially Served by Crisis Obs Facility	0%	54%
Number Initially Served by Crisis Facility	-	1,401
Number Referred to Crisis Facility by Mobile Team	-	248
Crisis Bed Occupancy Rate	85%	85%
Number of Crisis Observation Chairs Needed	**-**	**6**
Avg. Cost Per Crisis Bed / Chair Per Day	$ 1,820	$ 1,820
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 3,985,800**
Total Number of Episodes in Crisis Facility	-	1,649

Crisis System Needs Analysis - Mat-Su (continued)		
Diversion Rate of Mobile Team (From Crisis Facility)	70%	70%
% Served by Mobile Team	0%	32%
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	**-**	**1**
Cost Per Mobile Team	$ 300,000	$ 300,000
Total Cost of Mobile Teams	**$ -**	**$ 237,934**
Total Number of Episodes with Mobile Team	-	827
TOTAL Unique Number of Individuals Served	**1,756**	**2,583**
TOTAL Unique Number of MT / Crisis / Acute Episodes	**1,756**	**2,975**
TOTAL Inpatient and Crisis Cost	**$ 22,720,536**	**$ 16,978,294**
Change in Cost	**0%**	**-25%**
ED Costs (35% of Initial Acute with ED Estimate)	**$ 1,391,087**	**$ 401,389**
TOTAL Cost	**$ 24,111,623**	**$ 17,379,683**
TOTAL Change in Cost	**$ (6,731,939)**	**-28%**
NOTES	**Crisis Savings**	**$ 5,742,242**
	Total Savings	**$ 6,731,939**
Pharmacy not included		
35% of direct acute admissions go to ED first at $2,264		

Appendix D: Fairbanks Capacity Model Calculator

Crisis System Needs Analysis - Fairbanks		
	Baseline	**Optimized**
# of Crisis Episodes Annually (200/100,000 Monthly)	**2,332**	**2,332**
"Needed" Acute Beds for Population	*32*	*11*
Number of Acute Hospital Bed Days Needed Per Year	*11,803*	*3,354.09*
ALOS	*7*	*7*
Acute Inpatient Readmission Rate	*15%*	*15%*
Acute Bed Occupancy Rate	90%	90%
% Initially Served by Acute Inpatient	68%	14%
Number Initially Served by Acute Inpatient	1,585	320
Number Referred to Acute Inpatient From Crisis Facility	-	130
Number of Acute Inpatient Beds Needed	**32**	**11**
Cost Per Acute Inpatient Bed Per Day	$ 1,456	$ 1,456
Total Cost of Acute Inpatient Beds	**$ 17,185,018**	**$ 5,845,840**
Total Number of Episodes in Acute Inpatient	1,585	451
Diversion Rate of Crisis Facility (From Acute)	75%	75%
ALOS of Crisis Subacute Bed	4.2	4.2
Crisis Facility Readmission Rate	*15%*	*15%*
Difference Between Crisis and Acute Readmission Rates	0%	0%
% Initially Served by Crisis Subacute Bed	0%	0%
Number Initially Served by Crisis Subacute Bed	-	-
Number Referred to Crisis Subacute Bed by Obs Chair	-	521
Crisis Subacute Bed Occupancy Rate	90%	90%
Number of Crisis Subacute Beds Needed	**-**	**8**
Avg. Cost Per Crisis Subacute Bed Per Day	$ 1,456	$ 1,456
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 4,251,520**
Rate of Escalation to Subacute Bed	35%	35%
ALOS in Observation Chair	0.9	0.9
% Initially Served by Crisis Obs Facility	0%	54%
Number Initially Served by Crisis Facility	-	1,265
Number Referred to Crisis Facility by Mobile Team	-	224
Crisis Bed Occupancy Rate	85%	85%
Number of Crisis Observation Chairs Needed	**-**	**5**
Avg. Cost Per Crisis Bed / Chair Per Day	$ 1,820	$ 1,820
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 3,321,500**
Total Number of Episodes in Crisis Facility	-	1,489

Crisis System Needs Analysis - Fairbanks (continued)		
Diversion Rate of Mobile Team (From Crisis Facility)	70%	70%
% Served by Mobile Team	0%	32%
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	**-**	**1**
Cost Per Mobile Team	$ 300,000	$ 300,000
Total Cost of Mobile Teams	**$ -**	**$ 214,884**
Total Number of Episodes with Mobile Team	-	747
TOTAL Unique Number of Individuals Served	**1,585**	**2,332**
TOTAL Unique Number of MT / Crisis / Acute Episodes	**1,585**	**2,687**
TOTAL Inpatient and Crisis Cost	**$ 17,185,018**	**$ 13,633,744**
Change in Cost	**0%**	**-21%**
ED Costs (35% of Initial Acute with ED Estimate)	**$ 1,256,322**	**$ 362,504**
TOTAL Cost	**$ 18,441,340**	**$ 13,996,247**
TOTAL Change in Cost	**$ (4,445,092)**	**-24%**
NOTES	**Crisis Savings**	**$ 3,551,275**
	Total Savings	**$ 4,445,092**
Pharmacy not included		
35% of direct acute admissions go to ED first at $2,264		

Appendix E: Bibliography

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