**ALASKA STATE LEGISLATURE**
**HOUSE JUDICIARY STANDING COMMITTEE**
March 6, 2020
1:03 p.m.

**MEMBERS PRESENT**

Representative Matt Claman, Chair
Representative Harriet Drummond
Representative Gabrielle LeDoux
Representative Laddie Shaw
Representative Sarah Vance

**MEMBERS ABSENT**

Representative Chuck Kopp
Representative Louise Stutes

**COMMITTEE CALENDAR**

HOUSE BILL NO. 148
"An Act relating to solemnization of marriage."

- MOVED HB 148 OUT OF COMMITTEE

HOUSE BILL NO. 290
"An Act establishing an alternative to arrest procedure for persons in acute episodes of mental illness; relating to emergency detention for mental health evaluation; and relating to licensure of crisis stabilization centers."

- HEARD & HELD

**PREVIOUS COMMITTEE ACTION**

BILL: HB 148
SHORT TITLE: MARRIAGE WITNESSES
SPONSOR(s): REPRESENTATIVE(s) CLAMAN

| | | |
|---|---|---|
| 04/29/19 | (H) | READ THE FIRST TIME - REFERRALS |
| 04/29/19 | (H) | STA, JUD |

| | | |
|---|---|---|
| 02/20/20 | (H) | STA AT 3:00 PM GRUENBERG 120 |
| 02/20/20 | (H) | Heard & Held |
| 02/20/20 | (H) | MINUTE(STA) |
| 02/27/20 | (H) | STA AT 3:00 PM GRUENBERG 120 |
| 02/27/20 | (H) | Moved HB 148 Out of Committee |
| 02/27/20 | (H) | MINUTE(STA) |
| 02/28/20 | (H) | STA RPT 5DP 1DNP |
| 02/28/20 | (H) | DP: HOPKINS, THOMPSON, STORY, FIELDS, KREISS-TOMKINS |
| 02/28/20 | (H) | DNP: VANCE |
| 03/02/20 | (H) | JUD AT 1:00 PM GRUENBERG 120 |
| 03/02/20 | (H) | Scheduled but Not Heard |
| 03/04/20 | (H) | JUD AT 1:00 PM GRUENBERG 120 |
| 03/04/20 | (H) | Heard & Held |
| 03/04/20 | (H) | MINUTE(JUD) |
| 03/06/20 | (H) | JUD AT 1:00 PM GRUENBERG 120 |

BILL: HB 290
SHORT TITLE: ALTERNATIVE TO ARREST: MENTAL HEALTH CTR.
SPONSOR(s): REPRESENTATIVE(s) CLAMAN

| | | |
|---|---|---|
| 02/24/20 | (H) | READ THE FIRST TIME - REFERRALS |
| 02/24/20 | (H) | JUD, FIN |
| 03/06/20 | (H) | JUD AT 1:00 PM GRUENBERG 120 |

**WITNESS REGISTER**

SOPHIE JONAS, Staff
Representative Matt Claman
Alaska State Legislature
Juneau, Alaska
**POSITION STATEMENT:** Explained the Sectional Analysis for HB 290 on behalf of Representative Claman, prime sponsor.

STEVE WILLIAMS, Chief Operating Officer
Alaska Mental Health Trust Authority
Department of Revenue
Anchorage, Alaska
**POSITION STATEMENT:** Offered a PowerPoint presentation on the Crisis Now Model.

ALBERT WALL, Deputy Commissioner
Office of the Commissioner
Department of Health and Social Services
Anchorage, Alaska
**POSITION STATEMENT:** Offered an explanation on the 1115 Behavioral Health Waiver, pertaining to HB 290.

TIMOTHY QUIGLEY PETERSON, MD
Bartlett Regional Hospital
Juneau, Alaska
**POSITION STATEMENT:** Offered testimony in support of HB 290.

RAY MICHAELSON, Program Officer
Healthy Minds Focus Area
Mat-Su Health Foundation
Wasilla, Alaska
**POSITION STATEMENT:** Offered testimony in support of HB 290.

GENNIFER MOREAU-JOHNSON, Director
Division of Behavioral Health
Department of Health and Social Services
Anchorage, Alaska
**POSITION STATEMENT:** Offered testimony in support of HB 290 and answered questions pertaining to the proposed legislation.

**ACTION NARRATIVE**

1:03:02 PM

**CHAIR MATT CLAMAN** called the House Judiciary Standing Committee meeting to order at 1:03 p.m. Representatives Claman, Drummond, LeDoux, Shaw, and Vance were present at the call to order.

## HB 148-MARRIAGE WITNESSES

1:03:41 PM

CHAIR CLAMAN announced that the first order of business would be HOUSE BILL NO. 148, "An Act relating to solemnization of marriage."

1:04:10 PM

REPRESENTATIVE DRUMMOND moved to report HB 148 out of committee with individual recommendations and the accompanying fiscal notes. There being no objection, HB 148 was reported from the House Judiciary Standing Committee.

**HB 290-ALTERNATIVE TO ARREST: MENTAL HEALTH CTR.**

[Contains discussion of HB 86 and HB 181.]

1:04:37 PM

CHAIR CLAMAN announced that the final order of business would be HOUSE BILL NO. 290, "An Act establishing an alternative to arrest procedure for persons in acute episodes of mental illness; relating to emergency detention for mental health evaluation; and relating to licensure of crisis stabilization centers."

1:05:10 PM

CHAIR CLAMAN noted that there would be invited testimony from experts on the proposed legislation, who were well-suited for answering any questions the committee might have, and he asked the committee to refrain from asking questions until after invited testimony.

1:05:34 PM

CHAIR CLAMAN passed the gavel to Representative Drummond.

1:05:40 PM

CHAIR CLAMAN presented HB 290, as prime sponsor. He stated that people living with serious mental health disorders or emotional difficulties are subject to periodic recurring psychiatric emergencies or crises that require prompt medical attention and stabilization. He said that factors such as lack of timely access to essential services and support, substance use disorders, unstable housing and homelessness, and poverty

exacerbate these crises. He said that in Alaska, and across the nation, challenges are faced in how to address people in crises; current treatment options for those in crises are concentrated at either end of the behavioral health continuum of care, with long-term outpatient treatment options at one end of the spectrum and intensive inpatient treatment options at the other end.

CHAIR CLAMAN expressed that when comprehensive community-based mental health services are insufficient, the burden of dealing with those in crisis often falls on individuals and organizations whose primary duties lie outside the traditional scope of psychiatric destabilization. He stated that police officers, hospital emergency departments, correctional facilities, and social services providers are often on the front line of dealing with those experiencing a behavioral mental health crisis. He stated that these individuals and organizations are already at capacity in dealing with their primary functions in public safety, health, and nonbehavioral health services.

CHAIR CLAMAN stated that HB 290 would be the first step in adding a much-needed intermediate treatment option for those suffering from a mental health or substance abuse crisis. Created by the National Association of State Mental Health Program Directors (NASMHPD), the National Council for Behavioral Health, RI International, and suicide prevention groups make up the Crisis Now Model. He said that the Crisis Now Model is a type of community-based intervention to better serve those experiencing intermediate mental health crises. He explained that these facilities are open 24 hours a day, 7 days a week, 365 days a year, are staffed by mental health professionals, and have a "no wrong door" approach that is designed to provide prompt mental health evaluation and stabilization. He said that crisis stabilization centers have already proven to be a successful community tool in other states, including Arizona and Washington.

CHAIR CLAMAN stated that he and several other people went to Peoria, Arizona, a suburb of Phoenix, in December and visited a Crisis Now Center to see how the system works. He explained

that he was able to observe how police officers are able to drop people off at the door, how the center is able to take people in, and how treatment proceeds. He said that the centers have recliners instead of beds, because no one can stay for more than 24 hours. He expressed that the Crisis Now Model has dramatically improved public safety response and mental health access to treatment. He expressed that everyone he has spoken with, who has been to Arizona to observe the centers, is uniformly impressed with the effectiveness of the project and how well it serves the people in need of assistance. He said that there are currently no facilities like this in Alaska, and HB 290 would authorize the Department of Health and Social Services (DHSS) to write regulations to permit and license crisis stabilization centers in Alaska.

CHAIR CLAMAN stated that once regulations are in place, it is anticipated that interested providers will open crisis stabilization centers in Alaska's communities. He stated that Steve Williams, from the Alaska Mental Health Trust Authority, would be providing more information on the Crisis Now Model and crisis stabilization centers at the conclusion of this presentation. He said that HB 290 would give public safety professionals an essential alternative to improve public safety, and amend the code of criminal procedure to allow police officers, who have probable cause to arrest an individual, to elect to take the person to a crisis stabilization center as an alternative to jail. He explained that using the crisis stabilization center alternative would require a police officer to find that a person was experiencing a mental health or substance abuse crisis, and that treatment at a crisis intervention center would lead to a better outcome from both a treatment and public safety perspective. He stated that HB 290 would ensure that even if a person were taken to a crisis stabilization center, he/she could still be prosecuted for any related criminal activity.

1:10:24 PM

SOPHIE JONAS, Staff, Representative Matt Claman, Alaska State Legislature, explained the Sectional Analysis for HB 290 on behalf of Representative Claman, prime sponsor. She stated that

Section 1 of HB 290 would amend AS 12.25.030 by adding a new section providing peace officers with an alternative to arrest. She explained that an officer may, at his/her discretion, deliver a person to a crisis stabilization center instead of arresting the person, if the officer believes that the person is suffering from an acute episode of mental illness or voluntarily agrees to be taken to a crisis stabilization center. She stated that taking an individual to a crisis stabilization center, as provided for in this section, would not bar prosecution of the individual for alleged criminal activity or on charges for the original grounds of arrest.

MS. JONAS stated that Section 2 of HB 290 would amend AS 18.65.530(c), which already allows an officer to not make an arrest with permission from a prosecuting attorney, by adding a subsection providing that a peace officer is not required to make an arrest under AS 18.65.530(a), if the officer delivers the individual to a crisis stabilization center or evaluation facility. She stated that Section 3 of HB 290 would amend AS 47.30.705 by clarifying that a person who is gravely disabled or suffering from mental illness and poses immediate harm to self or others may be delivered to a crisis stabilization center or to an evaluation center, pursuant to AS 47.30.700.

MS. JONAS explained that Section 4 of HB 290 would amend AS 47.30.710(a) to provide for an examination by a medical professional within three hours for those brought to crisis stabilization centers. She stated that Section 5 of HB 290 would amend AS 47.32.010(b) to allow licensing of crisis stabilization centers under Chapter 32. Section 6 of HB 290 would amend AS 47.32 to add a new section providing for crisis stabilization center licensure standards. Ms. Jonas stated that Section 7 of HB 290 would amend AS 47.32.900 by adding a new paragraph that defines crisis stabilization centers.

1:12:57 PM

REPRESENTATIVE DRUMMOND passed the gavel back to Chair Claman.

1:13:14 PM

CHAIR CLAMAN opened invited testimony on HB 290.

1:13:45 PM

STEVE WILLIAMS, Chief Operating Officer, Alaska Mental Health Trust Authority (AMHTA), Department of Revenue (DOR), offered a PowerPoint presentation on the Crisis Now Model, titled "Enhancing Alaska's Psychiatric Crisis Continuum of Care." He stated that the work that has been going into the project is not just the work of AMHTA but includes many partners, such as: The Department of Health and Social Services (DHSS), the Department of Public Safety (DPS), the Department of Corrections (DOC), tribal health organizations, community providers, behavioral health organizations, local hospitals, and many others.

MR. WILLIAMS, referencing slide 2 of the PowerPoint presentation, stated that nationally, the Centers for Disease Control and Prevention (CDC) estimated that approximately 47,000 Americans will die of suicide this year; in Alaska that number is estimated to be [185], which is about 25 Alaska suicides per 100,000 national suicides. He expressed that often individuals in psychiatric crises are often first encountered by law enforcement, which is not the most effective approach for most situations. He said that the Anchorage Police Department (APD) reports that 200 of 400 calls it receives a month are for a behavioral health crisis of some sort and result in the individuals going to hospital emergency rooms. He said that nationally, DOC has become the default mental health provider for individuals.

1:15:59 PM

MR. WILLIAMS, referencing slide 3, stated that the continuum of behavioral health care has been eroding in Alaska for several years, despite efforts to "shore up" the system. He expressed that this has resulted in an inability to provide timely access to people in psychiatric crises or meet them where they are at, whether that be in their homes, shelters, or places of employment. He said that the erosion of the community behavior health system has led to individuals being diverted to DOC and hospital emergency rooms, and there has been a reduction in the

capacity at the Alaska Psychiatric Institute (API); ultimately, individuals in psychiatric crises are not getting the appropriate treatment in the appropriate settings needed to address their issues.

MR. WILLIAMS, referencing slide 4, asked, "Would this be the response and care system you would want, or design, for someone, an Alaskan, who experiences a cardiac arrest?" He asked whether anyone would want a uniformed officer, with a gun, to show up on the street corner to help an individual in such a situation. He expressed that mental health conditions are medical conditions, just like cardiac arrest, kidney disease, epilepsy, or asthma. He stated that the response should not be a law enforcement individual, it should be someone trained in mental health or with experience related to mental health conditions.

1:17:57 PM

MR. WILLIAMS, referencing slide 5, suggested that transforming the psychiatric crisis response system in Alaska has to start with a no wrong door approach: there must be no refusal and no eligibility requirements and, if someone calls, the response must be handled in the appropriate way, with the appropriate professionals, and the appropriate level of care.

1:19:02 PM

[MR. WILLIAMS played a video that was approximately three and a half minutes long, pertaining to the Crisis Now Model.]

1:22:41 PM

MR. WILLIAMS, referencing slide 7 of the PowerPoint presentation, expressed that a true mental health emergency response system is integrated across a region, a community, and a state. He stated that it utilizes peers and people with lived experiences to help a person in crisis to resolve his/her crisis and move forward. He reemphasized that it requires a no wrong door, 24/7, 100 percent acceptance policy, and he said there should be strong coordination across all levels of care.

1:23:19 PM

MR. WILLIAMS, referencing slide 8 of the PowerPoint presentation, stated that the Crisis Now Model, in terms of service delivery, partners closely with law enforcement, embraces recovery, and sees recovery as the outcome for individuals in crises. He stated that the Crisis Now Model ensures the safety of the patients and the professionals working in these settings and incorporates a significant number of people with lived experience as a part of the recovery and the services that get delivered. He explained that the Crisis Now Model is grounded in trauma, informed care, and has a zero-tolerance goal for suicides.

MR. WILLIAMS, referencing slide 9, pointed out agencies that have endorsed the Crisis Now Model. He stated that the Substance Abuse Mental Health Services Administration (SAMHSA) released its guidelines in the past month on how to respond to behavioral health crises. He said that SAMHSA highlighted the Crisis Now Model in its guidelines and the three components of that model: the crisis call center, the co-response, and the 23-hour crisis stabilization center. Referencing slide 10, Mr. Williams pointed out that a crisis call center has trained professionals who can receive calls from individuals in psychiatric crises and are able to resolve 90 percent of the issues over the phone. He expressed that for 7 out of the remaining 10 percent of individuals, the dispatch center will send out a co-response team, which includes a mental health clinician and a person with lived experience, and they will resolve those issues. He stated that the remaining three percent of individuals require more intensive service and will be dropped off at a 23-hour crisis stabilization center so that their needs can be met. He explained that the essential crisis care principles and practices are: zero suicide, trauma informed care, and patient and staff safety.

1:26:04 PM

MR. WILLIAMS, referencing slide 11, pointed out a "cross walk" of current systems as they exist and how they respond to crises. He highlighted that law enforcement is currently used as the

default response in the behavioral health crisis system, and in the Crisis Now Model it would be mobile crisis teams. He stated that typically when law enforcement officers respond, they end up waiting at the DOC or hospital emergency rooms for up to several hours for the person to get care in those settings. He explained that with a 23-hour crisis stabilization center, law enforcement can drop someone off, and in Maricopa County the wait time is less than five minutes for a professional from the crisis stabilization center to greet the individual and take him/her from the patrol car to the stabilization center. Mr. Williams, referencing slide 12, pointed out some of the successes in Maricopa County, which were highlighted in the video he had shown earlier.

1:28:12 PM

MR. WILLIAMS, referencing slide 13, asked, "What is going on in Alaska?" He stated that in 2018, the conversation about the Crisis Now Model started when then division director, Randall Burns, had just come back from a conference on the East Coast, had heard about the model, and started engaging entities, including AMHTA, on how the model could be implemented in Alaska. He said that the current default response system is, for the most part, inappropriate and most expensive. He said that another "big thing" that happened in 2018 was that DHSS submitted its application for the 1115 Behavioral Health Waiver to the Centers for Medicare and Medicaid Services (CMS) for approval. He explained that that is important because many of the services provided by the Crisis Now Model are outlined in the waiver application. He highlighted the work that many people at DHSS had done over the past few years in getting the application approved and ensuring that a piece of the financial foundation would be in place to implement the Crisis Now Model.

MR. WILLIAMS stated that in 2019, AMHTA worked in partnership with DHSS to look at what it would take to implement the Crisis Now Model in Alaska. He said that AMHTA procured a contract with RI International, which operates some of the Crisis Now Model pieces in Maricopa County, to come to Alaska and meet with three urban hubs in Anchorage, Fairbanks, and the Matanuska-Susitna ("Mat-Su") Borough and perform community assessments of

the gaps in needs for what it would take to employ the Crisis Now Model. He explained that the consultants spent a week in each community, met with representatives for several days, and at the end of the week there was a debriefing and identification of next steps. He said that the result of that work was a consultative report released in December of 2019 [hard copy included in the committee packet]. He said the report outlined 14 recommendations, 6 of which are listed on slide 14 of the PowerPoint presentation. He said that AMHTA had just procured a contract to provide project management for up to three years, with each of the three communities and their partners, to identify the steps needed to implement the Crisis Now Model. He asked whether the deputy commissioner would like to comment on the services outlined in the waiver.

1:31:44 PM

ALBERT WALL, Deputy Commissioner, Office of the Commissioner, Department of Health and Social Services, offered an explanation on the 1115 Behavioral Health Waiver ("the 1115 waiver"), pertaining to HB 290. He stated that the proposed legislation was arriving "at a very timely fashion," because the first phase of the waiver had been accepted and the department was "putting out" the second phase of the waiver. He expressed that up until this point in the history of Alaska, there had been no crisis stabilization facility types, and no means of payment for them should they exist. He stated that now, with the 1115 waiver, there was a way to pay for those facilities. He referenced three graphs [hard copies included in the committee packet], explaining that the differences between them were the age differences at the top, as the 1115 waiver is separated into three target groups by age. He said that there are three types of services: grant-funded, Medicaid state plan, and 23 new services offered under the 1115 waiver. He explained that up until the acceptance and implementation of these new service types, there would not have been the means to pay for a crisis stabilization center with no partial hospitalization, 23-hour holds, and other things of that nature. He explained that the 1115 waiver is coinciding in a timely fashion with the legislation proposed under HB 290, and there will now be a

payment mechanism for the services that would be delivered through the proposed model.

1:33:58 PM

MR. WILLIAMS continued with the PowerPoint presentation. Referencing slide 14, he pointed out 6 of the 14 broad-based recommendations from the Crisis Now consultative report. He said that the elements required to fully implement the Crisis Now Model were identified early on in multiple community conversations, as they would be great for urban communities but need continued conversations on the implementation in rural communities. He stated that something AMHTA, the committee, and many others are interested in is how to create accountability and what the performance metrics are for the Crisis Now Model. Referencing slide 15, he explained that AMHTA had sponsored a group of 26 individuals to go to Maricopa County and meet with the operators of the Crisis Now Model. He said that pictured on the slide was a subacute crisis stabilization center, which would be the location for someone who was not stabilized within 23 hours and needed a more acute level of care.

1:35:26 PM

MR. WILLIAMS, referencing slide 16, pointed out several entities that had sent representatives on the site visit to Maricopa County. He explained that there is broad-based interest and support moving forward, and these entities will be required to lay out the plan and develop and implement the services long term. He noted that AMHTA sponsored this trip, but many other people have gone on separate trips to look at the Crisis Now Model, including various legislators, local law enforcement, and DHSS through the Milbank Memorial fund. Mr. Williams, referencing slide 17, pointed out some of the highlights reported back from the AMHTA sponsored site visit. He said that it was important to be able to see how the model works, to talk to local law enforcement in Maricopa County to see their benefits and hear their support, and to understand what did not work previously and how well things work now. He said that it helped AMHTA connect with what needs to happen in terms of

policy regulation and statute in Alaska to make the Crisis Now Model effective.

MR. WILLIAMS, referencing slide 18, stated that the next steps moving forward would involve a project management team picking up the work that has been started to look into the 14 broad-based recommendations from the report, start to develop a plan for how to implement the Crisis Now Model in three communities, and continue to work with local health providers to get the model up and running in Alaska.

1:37:36 PM

MR. WILLIAMS, referencing slide 19, stated that AMHTA has been a partner in the process and will continue to be. He expressed that AMHTA will be involved in consultations and project management support. He stated that the trustees recently approved $2.6 million of new funding to help forward these efforts. He thanked AMHTA staff Katie Baldwin, Senior Program Officer; Eric Boyer, Program Officer; and Travis Welch, Program Officer, who have all worked closely with partners to help the Crisis Now Model move forward.

1:39:09 PM

TIMOTHY QUIGLEY PETERSON, MD, Bartlett Regional Hospital, offered testimony in support of HB 290. He stated that he has been an emergency physician in Juneau for 31 years, and one of the things he has seen happen over that time is that more people with anxiety and depression have been treating those issues with drugs and alcohol, which can sometimes unmask psychiatric illnesses, and as a result hospitals are seeing more cases of psychiatric illness. He stated that the system as designed, as said earlier, is straightforward. He explained that most people with behavioral health emergencies are brought to the Bartlett Regional Hospital emergency room by the Juneau Police Department when it is determined that someone needs to be "assessed." He said that this leads to a "whole gamut" of people who are brought to the hospital. As an example, he stated that there will be times when a schizophrenic person who was on his/her medication(s) and feeling good will not fill his/her

prescription, slowly decompensate, see a police officer, freak out because of previous issues with law enforcement, and then end up in the emergency room with a security guard and a police officer on each extremity while he/she is injected with medicine, just to keep him/her safe, when all that person really needed was a medicine refill. He said that he thinks that is a good example of why the emergency room is a bad place to take people "like this." He said that if someone were suicidal it would be a different scenario.

DR. PETERSON stated that security and nursing staff end up spending a lot of time being diverted to help with these situations and not doing the jobs that they are assigned to do. He stated that emergency rooms are noisy and chaotic places, and many people with mental health issues do not do well in that environment. He stated that he speaks for the American College of Emergency Physicians (ACEP) in Alaska, in that it is thankful for legislative support to API, because the bed capacity was "up to 50 or something from a year ago." He said that there will be times that someone will need a bed in Juneau and have to sit in the emergency room for a day or two, because someone from up North was sent down in a Medivac, at great expense, and is taking up a bed. He said that these individuals are "just in a bed, on the floor, get brought a meal, and someone stands there and looks at them." He said that this is a big expense for the hospital and the system does not work very well, which he said he thinks is clearly outlined by the recent presentation and the proposed legislation.

1:42:23 PM

REPRESENTATIVE DRUMMOND remarked that she is on the House Health and Social Services Standing Committee, which had spoken the day before about the psychiatric beds that are being made available at Bartlett Regional Hospital, Fairbanks Memorial Hospital, and in Anchorage, and she asked whether those beds are "full."

1:42:56 PM

DR. PETERSON answered that Bartlett Regional Hospital has 12 dedicated psychiatric beds in a locked unit, and they are almost

always full. In response to a follow-up question from Representative Drummond, he stated that the program has been in place for 15 or 18 years, and was designed to be regional so that people from all over the region, including Ketchikan, Petersburg, Angoon, and many others could receive care closer to home. He said that as it works currently, though, there will be times where there are Juneau residents up North, and Mat-Su residents down South. In response to another follow up question, he explained that the patient is put wherever a bed happens to be. He said that there is a ranking list at API for patients trying to be admitted. There was a teenage boy in Kodiak who was in the hospital waiting for a bed for 10 or 11 days, and his position on the list kept changing and no one could figure out what was happening. He said that those kinds of people will probably get their medicine if they are in the hospital, but they will not receive any therapy or resources to help them adapt back as a functioning member of the world. He said that by the time these individuals get to the mental health unit, their mental health conditions may have stabilized, but their abilities to cope and function have not. He said that this results in shorter admissions for those patients, which makes them more likely to "bounce back" and creates a revolving door of the same people back for treatment four to six weeks later.

1:44:37 PM

CHAIR CLAMAN asked whether Juneau had created a crisis intervention unit, and whether it was currently operating at Bartlett Regional Hospital.

DR. PETERSON replied that there is not currently a unit like the Crisis Now Model. He explained that currently Bartlett Regional Hospital has an on-call mental health practitioner, who will come to the emergency room three to five times in a 12-hour shift to assess someone who comes in with a mental health issue. He said often the people admitted are depressed, off their medications, or "back in town after a bad divorce elsewhere, and they don't even know where to turn." He said that often the staff at the emergency room are not qualified to help these

people, although they try their best, and the hospital is set up to take care of heart attacks and strokes, among other things.

1:46:08 PM

RAY MICHAELSON, Program Officer, Healthy Minds Focus Area, Mat-Su Health Foundation, offered testimony in support of HB 290. He stated that he oversees all projects that are related to behavioral health. He said that the Mat-Su Health Foundation shares co-ownership with the Mat-Su Regional Medical Center, and it invests a portion of the profits from the hospital back into the community in order to improve the health and wellness of Alaskans living in the Mat-Su area. He said that he supports the proposed legislation to change Alaska statute to allow for the creation of crisis stabilization services as an alternative to arrest for people suffering behavioral health crises. He expressed that the Mat-Su Health Foundation supports the proposed legislation, because it would pave the way for some of Alaska's most vulnerable residents to receive medical evaluation and care in lower-cost settings than hospital emergency departments, which would result in better outcomes and tremendous cost savings.

MR. MICHAELSON stated that he appreciated hearing about the trips to Maricopa County, as he was fortunate enough to be included on one of those trips. He expressed that the cost savings over time were impressive, as well as the number of law enforcement hours saved with the psychiatric boarding. He said that the potential to divert inpatient stays for acute mental health would be quite impactful on a financial basis. He said that the prevalence of mental health and substance abuse problems is increasing in Alaska, and the savings could be significant for the state by having a crisis stabilization option for law enforcement. He stated that the average annual growth rate for visits to the Mat-Su Regional Medical Center Emergency Department, by patients with a behavioral health diagnosis, grew 20 percent from 2015 to 2017, due in part to the opioid epidemic and the shortage of outpatient access. He said that from 2014 to 2017 the number of behavioral health assessments required for patients in a crisis in the emergency department grew from 349 annually to more than 1,000.

MR. MICHAELSON stated that HB 290 would allow police officers to bring patients to a crisis stabilization center in Mat-Su, instead of to the Mat-Su Regional Medical Center or the Mat-Su Pre-Trial Facility. He said that in 2013, the "Mat-Su Community Health" needs assessment allowed Mat-Su residents to rank the health issues that they were most concerned about, and the top five issues were all related to mental health and substance abuse. He said that as a follow up to the community health needs assessment, there was a Mat-Su Behavioral Health environmental scan, in which policies were looked at that could address barriers to access to care and improve the behavioral health systems. He stated that one recommendation from that report was to add a crisis stabilization center to the behavioral health continuum of care; however, current Alaska statute does not allow for that to happen, and HB 290 would change that. He said that additional recommendations out of the behavioral health environmental scan included the crisis line and mobile crisis services. He summarized that system changes, such as the proposed legislation would allow, would alleviate suffering for people in behavioral health crises, while delivering significant cost savings, especially for Alaska's Medicaid program. He reiterated that the Mat-Su Health Foundation is in strong support of HB 290 and urges the passage of the proposed legislation.

1:50:21 PM

CHAIR CLAMAN closed invited testimony on HB 290.

1:50:40 PM

REPRESENTATIVE LEDOUX asked whether anyone other than police officers would be allowed to take people to "crisis intervention" centers, under the proposed legislation.

1:51:04 PM

MR. WILLIAMS replied that anyone would be served and admitted, by various sources, to a crisis stabilization center. He said that if he were in a mental health crisis, then he could seek

services there himself, a family member could assist him in getting there for services, or Emergency Medical Services (EMS) could drop him off; it would not be limited to law enforcement.

REPRESENTATIVE LEDOUX asked whether crisis stabilization centers exist currently in Alaska, whether the current law requires another law to allow police officers to take people to crisis stabilization centers, or whether they exist at all.

1:52:01 PM

CHAIR CLAMAN remarked that they do not exist - "period."

1:52:07 PM

MR. WILLIAMS clarified that there is the Providence Psychiatric Emergency Department, in Anchorage, which was constructed as a piece of the new API and was supposed to be the single point of entry. He explained that it has eight beds in Anchorage, and it tries to stabilize people within 23 hours, but it is inadequate. He added that while the service is critical, it is a slightly different model from what is being operated in Maricopa County, specifically around the use of peers as a key component of services.

1:52:54 PM

REPRESENTATIVE LEDOUX asked whether the Providence Psychiatric Emergency Department is a lock-down facility and remarked that she didn't think it was a place to which someone could just go for 24 hours.

MR. WILLIAMS replied that he was not going to get into the specifics of whether it is a lock-down facility, but he knows that the model is based on trying to stabilize someone in less than 24 hours and, if not, make a recommendation for someone going to API or a higher level of care in other communities.

1:53:42 PM

REPRESENTATIVE DRUMMOND remarked that Mr. Williams' presentation resulted in bringing questions to mind. She stated that she serves on two other committees, in which she is hearing of an overwhelming need for mental health services. She said that the proposed crisis stabilization center seems to be at the center of a continuum of care issue that Alaska has. She stated that the day before in the House Health and Social Services Standing Committee, testimony had been heard regarding HB 86, regarding mental health and contract bids. She said that in the House Special Committee on Education, they were talking about the Department of Education and Early Development's (DEED's) approach to teaching children who come to school with Adverse Childhood Experiences (ACES), with trauma informed awareness. She stated that high school students are asking for a mental health curriculum, and that is being addressed through HB 181. She said that former Governor Bill Walker's administration had a "cross-department summit" in Anchorage in Fall 2018, where it was acknowledged that quite a few State of Alaska employees suffered or acquired secondary trauma through their work as public safety officers, working with dysfunctional families in the Office of Children's Services (OCS), or working with suicidal people in all kinds of situations.

REPRESENTATIVE DRUMMOND asked who would be tying all these topics together. She remarked that it "can't be up to me as a legislator, who just happens to be on the right three committees to pull this together." She stated that she had just been assigned to the House Judiciary Standing Committee, as well as Representative Vance, and this was opening her eyes to the needs across the state. She expressed that the biggest issue missing from the presentation Mr. Williams had given pertained to education, and she asked, "What about the children?" She remarked that there were people from the University of Alaska who were on the trip to Maricopa County, but there was nothing about DEED or school districts included in the presentation, and she asked how children would be addressed under the proposed legislation.

1:56:42 PM

MR. WALL answered that the behavioral health system of care has been in disarray in Alaska for quite some time, and DHSS is aware of that. He stated that it has traditionally been funded through a blend of grants through non-profit organizations and Medicaid services in a limited fashion. He advised that the behavioral health system was designed years ago and has not evolved with the current situation in health care, and it needs to do so. He stated that there is a broad discussion and a plan for changing that system, and crisis stabilization is a piece of that change. He said that Representative Drummond was correct, there are many elements to the system. He said that DHSS has had conversations with EED recently at a summit in Mat-Su, around school-based services and education, and is looking specifically at opportunities in that area. He related that Mat-Su has a behavioral health program in its school system that is running very well. He stated that Senator von Imhof brought that group together, and DHSS is glad to be a part of it.

MR. WALL stated that there is a very broad-based discussion around the implementation of care. He explained that SAMHSA has a continuum of care that has been developed over time, which has tremendous amounts of research and clinical thought behind it, and when a state looks at what its behavioral health system should look like, it compares its system to that continuum of care. He stated that it is evident where gaps in service exist in Alaska, and DHSS is actively looking to fill them. He said Alaska's service of care has been driven for a long time on the end of "expense of acuity," as shown in the video clip and explained by Mr. Williams previously. He said that there is a tendency to hold on to a behavioral health problem until there is an absolute emergency, and deal with it in either an emergency room or acute psychiatric setting.

1:59:38 PM

GENNIFER MOREAU-JOHNSON, Director, Division of Behavioral Health, Department of Health and Social Services, offered testimony in support of HB 290 and answered questions pertaining to the proposed legislation. She addressed a question from Representative Drummond pertaining to adverse childhood experiences. She explained that the three graphics, referenced

earlier by Mr. Wall, show the three populations targeted by the 1115 waiver: the substance use disorder population, the mental health population, and the at-risk families. She said that the idea of the 1115 waiver is to drive down the cost of care and provide appropriate care where needed. She stated that at-risk families are in the section in which multi-generational returns on services provided are being investigated. She explained that the point of entry for at-risk families at the early-intervention end of the continuum is entirely based on adverse childhood experiences; the data comes from the Alaska Longitudinal Child Abuse and Neglect Linkage Project, which came out of the Division of Public Health (DPH).

MS. MOREAU-JOHNSON said that Jared Parrish, an epidemiologist, established "stressors" - indicators that would likely result in child abuse and neglect - which are the criteria for at-risk families. He worked with [the department] to "crosswalk" the indicators from his study to diagnostic codes. She said that there are 17 criteria, including: homelessness, incarcerated parents, substance use, and atypical parenting situations. She said that the services available through home-based family therapy are specifically targeted as protective factors to ameliorate the impact of adverse childhood experiences. She stated that the federal government approved this, because a study from the Alaska Mental Health Board demonstrated that the number of adverse childhood experiences have a correlation to Medicaid expenditure, and it saves money to reduce the impact of ACES.

2:01:47 PM

REPRESENTATIVE DRUMMOND asked for clarification on what SAMHSA is.

2:02:06 PM

MR. WALL answered that SAMHSA is the Substance Abuse Mental Health Services [Administration], which is a branch of the federal government. He said that he could provide a link to a good modern continuum of care.

2:02:28 PM

REPRESENTATIVE VANCE remarked that the Medicaid expansion has increased the obligation Alaska has in its "portion of carrying that burden," which has affected the budget. She asked what the 1115 looks like "in comparison to that," and how it would affect future growth. She expressed that the visible mental health issues are only "the tip of the iceberg," and asked for explanation on the services that might be needed.

2:04:02 PM

MR. WALL answered that DHSS would be happy to make itself available to answer specific questions by members of the committee at any time. He stated that the history of behavioral health in the state is funded primarily through a combination of behavioral health grants, which are generally funded and have no federal match attached to them, and the Medicaid portion, which is limited, administratively burdensome, and costly. As an example, he said that traditionally services provided under clinic services and rehabilitation ("rehab") for behavioral health are billed in small increments of time, which requires a great deal of paperwork and has a limited amount of reimbursement with a lot of administrative overhead. He said that the 1115 waiver pays for services in a different way, which is in a bundled fashion, requires a lot less administrative overhead, and allows DHSS to access the federal match for it as well.

MR. WALL explained that the plan for a move to the 1115 waiver has been around since Senate Bill 74 was passed [in 2016, during the Twenty-Ninth Alaska State Legislature]. He said that grants have been reduced over time, so the general fund has gone down, and the Medicaid pieces have been used to fill in where needed. He said that overall, healthcare is costly and tends to increase. He explained that DHSS is actively engaged in cost containment and has addressed the 1115 waiver from a cost containment point of view.

2:06:18 PM

MS. MOREAU-JOHNSON pointed out that her department is in contract with an actuarial firm and is working very closely to do analysis around expenditures and, as Mr. Wall had described, the actuaries are monitoring the situation with the idea being that if there is an uptick in the consumers of these services, it will be at the lower end of the cost of care.

2:06:47 PM

REPRESENTATIVE VANCE asked whether the type of additional care that would be needed for 30 percent of patients, as described by Mr. Wall previously, would be "API type of care," and whether there are preparations in place for an increase in volume.

2:07:21 PM

MR. WALL answered that the numbers being used came from the crisis intervention stabilization model out of Arizona and are specific to Maricopa County and reflect how many stabilizing interventions were made during a specific time. He said that as mentioned previously, 90 out of 100 of those cases would be stabilized over the phone. He said that the remaining cases would not necessarily require an API level of care, meaning they would end up in a stabilization center, but that is not precluding an inpatient level of care because some of those cases "do go, but those were not included in that number of three." He explained that the three sets of numbers used were for those that were stabilized in a call center, those that were stabilized by mobile behavioral health teams, and those that go to a stabilization center.

2:08:17 PM

CHAIR CLAMAN remarked that this means that 90 percent are stabilized on the phone, 7 percent are stabilized by mobile teams, and 3 percent are stabilized in a crisis stabilization center. He said that within the 3 percent is a smaller percentage that will go to what would be called an API in Alaska, to an involuntary commitment setting for longer care treatment than can be received in a 23-hour window.

MR. WALL replied that that is potentially correct. He pointed out that solving a problem on the phone is astronomically less expensive than doing it in an emergency room.

2:09:00 PM

REPRESENTATIVE VANCE asked how many central locations DHSS was looking into, given how large Alaska is and the rural areas that are in the state.

2:09:23 PM

MR. WALL answered that the process would be phased in over time and there is a rural application, which DHSS is working on with tribal partners. He expressed that an exciting thing about going to Maricopa County was that a tribal liaison was available to answer questions. He said that while Arizona is not the same as Alaska, there are remote areas, such as a tribal village at the bottom of the Grand Canyon, that are only accessible by mule. He stated some of the ways that this model was adapted to Arizona could potentially be adapted for the model in Alaska. He said that there are different ways to handle mobile teams, like in the village mentioned before. He explained that all the adults were trained, and the phone was traded amongst them. He said that there are interesting applications that can be applied in Alaska, and he mentioned that Arizona has Medicaid approved transportation for horses. He added that he was not suggesting that would be applied in Alaska. He explained that there are different ways to adapt for rural areas as needed, and DHSS will be working towards that. He said that the initial push will be for urban areas, as they have the highest volume of cases, and DHSS will be looking to put up a full system that is sustainable in those areas and then work with other areas.

2:10:56 PM

MS. MOREAU-JOHNSON remarked that the 1115 waiver is designed around regions, and the idea is to develop capacity in every region. She said that there will be monitoring across every region in the state, and there is a contract with an administrative services organization tasked with building

capacity and doing continual gap analyses where services are missing. She said that the idea is not just to build up services in Anchorage, Fairbanks, and Mat-Su and fly people in, but to serve people within their hub communities as much as possible. She said that AMHTA helped fund an infrastructure gap analysis, which should be released by March 15, 2020, in which it went to every regional hub and visited 75 providers across the state to talk about services.

2:11:56 PM

REPRESENTATIVE VANCE remarked that she noticed that the fiscal notes included health facilities, licensing certification, Medicaid services, and trooper detachments, but did not have any information regarding facilities and the "RTC," or response team. She asked whether someone could talk more about the fiscal notes for these things.

2:12:45 PM

MR. WALL answered that all those things have not yet been determined. He said that DHSS is in the process of working with the bill sponsor and is happy to work on the proposed legislation as it develops. He stated that there are some service lines within the Crisis Now Model that will require licensure, while others will not. He said that some of the service lines could be handled through regulation, some could be handled by a service provider "standing it up and doing it," and others would have to be put into statute.

2:13:19 PM

CHAIR CLAMAN remarked that his understanding of the RI International model and experiences in Phoenix, Arizona, in terms of funding the crisis intervention center, is that the organization that runs it is able to fund operations through "billables," although there may be some capital expense when getting started. He suggested that Mr. Wall or Mr. Williams might be able to give more information on who would build a crisis center once permission is in place.

2:13:54 PM

MR. WALL replied that that is true, the model is designed to be a billable service. He said that there are different levels of service and the call center, mobile crisis teams, and the crisis stabilization centers are three separate lines of service. He said that in Maricopa County each line of service is handled by a different type of organization, and they are all handled in a slightly different manner. He added that in Maricopa County services are run under managed care, and it is a slightly different model from what would be seen in Alaska.

2:14:36 PM

MR. WILLIAMS remarked that he thinks it is important for the committee and anyone watching the meeting to understand that these are the beginning phases of looking at what it will take to implement the Crisis Now Model in one to four communities, which is why there is project management under contract to start working and do the proformas for the costs that will be associated with capital facility costs and operations. He said that as work is done to identify how to implement the Crisis Now Model to meet the needs of local communities, that information will become clearer and will be readily available as it is generated.

2:15:30 PM

REPRESENTATIVE LEDOUX asked for clarification on what an 1115 waiver is.

2:15:48 PM

MR. WALL answered that there is standard Medicaid under federal statute, and there are different ways that requirements can be waived for standard Medicaid, which are applied for through several different types of waivers. He said that Alaska already has some waivers in the state, and that Senior and Disabilities Services (SDS) operates under a complex 1915(c) waiver. He said that the 1115 waiver is a section in federal law that can be applied to in order to get certain requirements waived. He said

that there are basically two types of waivers: one waives how to become eligible, and the other waives the types of services involved and how to pay for those services. He expressed that it is a complex system.

2:17:02 PM

CHAIR CLAMAN remarked that a large measure of what is seen with an 1115 waiver is that primarily federal funds pay for treatment services, whether that be for substance abuse, mental health disorders, or psychiatric issues. He said that there is more than one type of waiver in terms of what treatment is provided, but largely federal funds are used, because it is an expansion of Medicaid, and the people who are eligible for that do not typically have insurance; a waiver allows them to get treatment. He expressed that if he explained that incorrectly, then there were two people present who could offer a correction.

MR. WALL remarked that the 1115 waiver is not a "standard package." He explained that many states have an 1115 waiver and they all look vastly different, and sometimes the waivers do not even pertain to mental health. He said that the reason Arizona has been talked about so much, and people went there to study the model, is because the waiver there is the closest of any state to the waiver in Alaska, although they are still different from one another. He expressed that Ms. Moreau-Johnson is the DHSS's expert on waivers, and she could explain in more detail.

2:18:19 PM

MS. MOREAU-JOHNSON remarked that Mr. Wall had described the 1115 waiver correctly. She said that the way she likes to look at it is that the 1915(c) waiver, which SDS has purview over, is for individuals waiving a level of care; individuals waive the level of care they would otherwise receive in a nursing facility. She said the 1115 waiver is the federal government allowing, through the section of Title 19 that Mr. Wall had described, to waive the rules of the program; therefore, instead of an individual waiving something, it is the program rules that are being waived. She said that to Chair Claman's point, many people served by [the Division of] Behavioral Health fit in to the

expansion population, which is "round numbers of 90/10 match, the 90 percent federal, 10 percent state match." She said that Chair Claman was correct in saying that any population can fit into that, and when looking at the populations, "the different people being served will have varying federal matches attached to their eligibility."

2:19:28 PM

REPRESENTATIVE LEDOUX asked, "What rules are getting waived?"

2:19:36 PM

MS. MOREAU-JOHNSON answered that there are several rules being waived. She said that Representative LeDoux's question is like the question that led to how the design of the waiver was approached, and she asked, "What do we want to waive?" She said that one of the primary rules that was waived was the "rule of comparability in Medicaid." She said that under traditional Medicaid through the state plan, any service that is offered must be available to any Medicaid eligible person. She expressed that her department wanted to target populations, so the comparability rule was waived, and populations were designed around data that showed who tend to be "high consumers." She explained that one of the cost-containment strategies is to target the populations that tend to be at the high end of care and design services to keep them.

REPRESENTATIVE LEDOUX expressed that her understanding was that anyone could be accepted to a crisis stabilization center under the proposed legislation, and she said she found it confusing that Ms. Moreau-Johnson was now saying it would be targeted towards "certain populations."

MS. MOREAU-JOHNSON answered that Representative Ledoux was "right to be confused" and said that the populations she was explaining are the populations that are eligible for Medicaid coverage. She explained that the difference is between the model and the services being proposed in the 1115 waiver. She said that services will be covered when a claim comes through and will be paid for through Medicaid, for anyone who is

Medicaid eligible and meets the qualifications. She said that the Crisis Now Model has 100 percent acceptance, and the "phone doesn't get answered with the question, 'What is your Medicaid ID number?' The phone gets answered with, 'What do you need?'"

2:21:37 PM

MR. WALL commented that it is important to separate what crisis stabilization is from the 1115 waiver. He explained that the 1115 would be used as a vehicle to provide payment for a certain group of people. He said that this does not meant that the 1115 waiver is crisis stabilization, as they are two different things. He said there are people with regular Medicaid and people with no payment capacity whatsoever, and all kinds of people will be able to go to a crisis stabilization center and be served. He said that the mechanism that was used to set it all up in the first place was the 1115 waiver. He summarized that it is somewhat complex, and the two are separate entities.

2:22:31 PM

REPRESENTATIVE DRUMMOND, referencing the three charts provided by DHSS, remarked that the "blue stuff" is the 1115 waiver. She asked for clarification on "what are we getting and what is it costing?" She mentioned grant funding and asked whether this was how behavioral health used to be administered. She said that she had heard someone mention earlier that the "patchwork is not working, so we're fixing it." She asked whether the Medicaid state plan is general fund dollars, and the other services federal dollars.

MR. WALL answered that Ms. Moreau-Johnson has been giving presentations on that very topic to the DHSS's partners in many legislative settings for the past year, and offered his understanding that she would be happy to give the presentation to Representative Drummond. He said that the presentation is approximately an hour and it might be better to "do it on the side."

2:23:49 PM

MS. MOREAU-JOHNSON remarked that Representative Drummond's question pertains to funding across the three different colors on the charts. She said that the grant lines are funded through some federal grants and some state funded grants. She explained that the orange bars on the chart are the Medicaid state plan, which is the match mentioned earlier; the federal match is drawn down in varying amounts depending on the eligibility group being served. She expressed that the problem with the state plan is that the services allowed come straight out of Title 19, referred to earlier by Mr. Wall, which is a list of services that is very limited in nature, and behavioral health has not traditionally fit into that list very well. She said that another rule that was waived through this process was to get away from the medical model, which allowed for the design of more services that people will be willing to engage with and are more appropriate in the behavioral health world.

MS. MOREAU-JOHNSON stated that all the services in the orange and blue on the charts are Medicaid dollars, which fit in as a revenue source for the people providing a service in crisis stabilization when provided to someone who is Medicaid eligible. She said that she does not want the 1115 to be a distraction from HB 290, but said that the reason it is important is because it will be a primary funding source for the proposed legislation. She said that she thinks approximately 80 to 85 percent of the costs in Arizona were covered by Medicaid.

2:25:36 PM

REPRESENTATIVE VANCE asked for clarification on whether the intent for HB 290 is just to establish a procedure so that the process of setting up mechanisms in Alaska for an alternative to arrest can begin and would not directly impact setting up the crisis stabilization centers.

2:26:17 PM

CHAIR CLAMAN answered that Representative Vance was partially correct and HB 290 would do two things. First, in the criminal code it would provide an alternative to arrest option for officers. Second, it would give DHSS the authority to write the

regulations that would allow for it to start standing up the process. He said that the timeframe he foresees is that if the proposed legislation were to pass in the current session, it would take DHSS 6 to 12 months to get the regulations in place, and the goal would be to have regulations in place so that by the next fiscal year, meaning the beginning of 2022, one or more of these facilities could be started in one of the communities that have been described. He stated that the finer details would be left to regulations, and without the statutory change that specifically allows for DHSS to have crisis stabilization centers within its range of care options, the process of drafting the regulations to make that possible cannot begin.

2:27:46 PM

REPRESENTATIVE VANCE asked how much training police officers have, regarding mental illness, to be able to make an identification, and she asked whether DHSS thinks it is adequate given the high number of mental crises in Alaska.

2:28:09 PM

CHAIR CLAMAN responded that he did not want to speak for police officers, although he said he has been in contact with public safety and local police departments in the state, and the answer he has heard is that police officers do receive training in dealing with mental health and substance abuse crises. He stated that the reality is that the population police officers see every day is people having mental health and substance abuse issues. He said that the police officers are not trained as psychologists, but they must make these decisions as part of their work daily, as that is what they are dealing with.

2:29:10 PM

MR. WILLIAMS commented that the training academies do cover mental health issues in a very small piece of their overall training, and there are communities that have crisis intervention team training. He said that AMHTA has worked with communities in Anchorage, Fairbanks, and Juneau. He stated that the Mat-Su Health Foundation and AMHTA have worked with the

troopers in the Palmer and Wasilla police departments to provide a more intensive 40-hour crisis intervention team training, for which officers and other first responders voluntarily agree to apply. He explained that the intent is never to train a police officer to be a clinician but to be able to recognize whether a situation requires more work and questions of the individual or those around him/her.

2:30:13 PM

REPRESENTATIVE VANCE stated that she had met a man that day from a rural village in a region that has the highest rate of suicide in Alaska. She asked whether there was a partnership to work with the Village Public Officer Safety Program (VPSO) and whether it was possible to have that community as part of the first regional model, as it currently has the greatest need for intervention.

2:30:56 PM

MR. WALL replied that DHSS works with every region, particularly around behavioral health emergencies and crises, and he reiterated that this model would first be rolled out in an urban setting, because the infrastructure necessary to run it requires that. He explained that it would then be adapted to each region and work would be done to put the model in place, including with the VPSO structure.

2:31:27 PM

REPRESENTATIVE LEDOUX asked whether anything is anticipated to be "between the crisis stabilization center and API," meaning something that could take care of people for a few days instead of committing them to API indefinitely.

2:32:04 PM

MR. WILLIAMS answered that the model in Arizona, its three components having been discussed earlier, has a fourth component that had not yet been discussed. He said that this component is a subacute unit, and if someone cannot be stabilized in a 24-

hour period and needs a higher level of care, then he/she can be referred there or to other services like API, if required.

2:32:39 PM

CHAIR CLAMAN remarked that for the short term in Alaska, because the state is trying crisis stabilization first, someone who is not stabilized in the first 23 hours would likely be sent to API or an equivalent. He expressed that in the long term, a goal would be to have the next level of care in place.

2:32:57 PM

REPRESENTATIVE LEDOUX asked Mr. Williams what the role of AMHTA would be in paying for the proposed facilities.

2:33:25 PM

MR. WILLIAMS answered that over the past 25 years AMHTA has had the role of helping to identify and invest in a model that can enhance the system of care and improve outcomes for Alaskans. He said that AMHTA provides funding to explore that and acquire continued project management and consultation. He expressed that as the pieces of standing up and operating the components of the proposed model come into play, he anticipates AMHTA would be playing a role in that as well.

2:34:21 PM

REPRESENTATIVE DRUMMOND, referencing Representative Ledoux's question about what happens between crisis stabilization and API, asked where the subacute treatment fits on the chart, with acute being the third column, outpatient services being the second column, and residential and inpatient being the third column. She asked whether subacute would be before acute, or after.

2:34:43 PM

MR. WALL answered that it could be a bit of both. He said that traditionally there is something in behavioral health, or even

in respite services for surgeries and such, that are called "step-down units." He said that someone can either be in a step-down unit prior to going to a higher level of acuity or be in one after he/she is discharged from a higher level of acuity. He said that it is a level of service that needs to be further developed in Alaska. The situation is evolving as things move forward, and the plan is to eventually put everything into place.

2:35:25 PM

REPRESENTATIVE DRUMMOND commented that it did not surprise her to see all the costs related to mental health issues. She remarked that private health insurance has not covered mental health costs for years. She said that the program DHSS is in might provide a few sessions of counseling, but certainly not inpatient mental health services. She expressed that she is glad to see society "waking up to the fact" that there are all kinds of issues, particularly that ACES result in medical costs later in life. She said that Dr. Vincent Felitti had been in Alaska several years ago and introduced ACES, which he had discovered accidentally in a long-term nutritional study that he had done with Kaiser Permanente on thousands of patients. She said that is when DEED started talking about how to incorporate ACES into its understanding of how children learn.

2:36:52 PM

REPRESENTATIVE LEDOUX, referencing fiscal notes [hard copies included in the committee packet], remarked that the fiscal note from healthcare services says that crisis stabilization centers will require state licensure, periodic surveys, ad hoc inspections, and will require two full-time registered nurse positions to fulfill these requirements. She asked whether this was normal, in respect to licensing. As an example, she asked whether nurses would be sent as "par for the course" if the Providence Psychiatric Emergency Department or API were inspected.

2:37:59 PM

MR. WALL answered that there are a variety of different surveys and inspections that are done on facilities. Some require clinical review, and those that do will have clinical personnel, like a nurse, to perform them. He said that there are other types of surveys that do not require clinical review, but those are compliance surveys that pertain to physical structure and procedure. He said that in the case of the proposed legislation there would be a need for clinical review.

REPRESENTATIVE LEDOUX remarked that the zero-fiscal note from the Office of the Commissioner stated in its analysis that DPS will need funding support to train officers in crisis intervention and mental health first aid, and she asked whether that is something that DPS does already.

MR. WALL replied that the fiscal note is from the Department of Public Safety, thus he would defer questions about it to that department. He said that there are a couple of different ways to handle the licensure and certification process, that would affect a fiscal note.

2:39:32 PM

REPRESENTATIVE LEDOUX remarked that she was curious as to why it would take different training to refer someone to one of the centers under the proposed legislation when officers are already taking people to API.

2:39:46 PM

MR. WILLIAMS answered that he did not think that there would be training required to take someone to one of the proposed crisis stabilization centers, but there would be basic one-on-one training as to what could be presenting as a mental health situation, which allows an officer to have more recognition and tools to assess a situation and respond appropriately. He said that it would not be about a clinical diagnosis or whether training is needed to identify that the deputy commissioner needs to go to a crisis stabilization center or not. He said that if an officer were to see that as the appropriate approach,

with or without training, he/she should be able to make that call on the street.

2:40:38 PM

REPRESENTATIVE SHAW, referencing Representative LeDoux's point, remarked that he taught at the Public Safety Training Academy, and over a 400-hour training session for a trooper the academy will adjust the curriculum accordingly to increase the level of training that might be needed in a certain area. He said that currently "we're looking at a totally different scenario" in the training because of behavioral health issues. He expressed that he thinks there is a lot more sociological and psychological training that needs to be established. He said that this was highlighted in the VPSO program the other day, as it is currently being worked on to increase the value of the VPSO program in rural communities. He mentioned "one trooper one riot," saying that one trooper covers ten villages, and without the VPSO interaction the value of law enforcement's behavioral health support is lost without training. He said that trying to build the curriculum for the trooper and VPSO program to deal with behavioral health issues is "huge." He expressed that it must either be added to the training, or some other type of training will have to be removed. As an example, he said that constitutional law is taught at the academy, and he suggested a few hours of that be cut. He expressed that it is difficult to add a week or two to law enforcement training, because there is a desire to get the police officers out on the street. He stated, "Get them into a field training program, then, after the fact, if training becomes available, additional training relative to behavioral health, then they can actually volunteer to do that."

2:42:26 PM

REPRESENTATIVE VANCE remarked that the analysis on one of the fiscal notes says that crisis stabilization centers require state licensure, and she said that essentially this would be paying for two full-time Health Facility Surveyors I [positions]. She asked why this would be needed at this time for HB 290, considering that it was outlined earlier that the

purpose of the proposed legislation was to allow officers an alternative to arrest, and allow DHSS to adopt regulations. She expressed that it seems like that is a step ahead of where things need to be.

2:43:15 PM

MR. WALL answered that there is some oversight regulatory control that CMS requires of things that are licensed and paid for under Medicaid. He said that surveying a facility, whether it be a hospital, API, or a crisis stabilization center, is required by CMS to ensure that the facility is in compliance with the regulations that CMS has over them. He said that the federal government requires any facility that "touches Medicaid money" to be surveyed by health care facility licensing inspectors on a periodic basis and be able to respond to complaints from people in that center. He explained that the positions that would be asked for in the licensure process would be doing that line of work.

2:44:50 PM

MR. MICHAELSON, in response to a request from Representative Drummond, restated the statistics he had previously shared regarding the 20 percent increase in numbers of patients with behavioral health crises accepted by the Mat-Su Regional Medical Center Emergency Department between 2015 and 2017 and the increase in the number of behavioral health assessments that were required in the emergency department as a result of behavioral health emergencies, which was from 349 in 2014 to more than 1,000 in 2017.

REPRESENTATIVE DRUMMOND remarked that it looked like the behavioral health assessments due to emergencies jumped from approximately one a day, to around three a day in that three-year period.

2:47:32 PM

MR. MICHAELSON answered that is correct.

2:47:40 PM

MR. WILLIAMS commented that he wanted to follow up on a question Representative Drummond had raised at the beginning of the questions and answers session, inquiring how the proposed model would relate to intervening with youths and adolescents who are in psychiatric crises. He expressed that he would like to make it clear that two of the three components discussed during the meeting would address youths who are in psychiatric crises. He said that a youth or adult could call the crisis call center and a situation could possibly be deescalated over the phone. He said that the mobile co-response teams could respond to youths in the community, and in Maricopa County those teams often respond and intervene at schools, which was learned on the site visit to Arizona. He said that the crisis stabilization center is currently targeted towards adults, but that would not necessarily need to be a limitation going down the line. He explained that ways could be investigated to adapt the model or create different approaches for that level of care.

2:49:00 PM

REPRESENTATIVE DRUMMOND commented that 20 years ago there were no long-term psychiatric beds in the state for a youth in crisis. She said that since then the North Star Behavioral Health System has expanded significantly so that youth in crisis can be hospitalized in state, rather than being "sent to Utah or Texas." She said that progress has been made, but she thinks those are partially locked facilities. She said that the Anchorage school district sends teachers to North Star to make sure the youths are keeping up with their academics, and regardless how long they are there, they receive those services. She asked what an intermediate service might look like for people younger than the age of 21.

MR. WILLIAMS answered that he did not know that he could answer that question at that time, but he could follow up.

2:50:20 PM

MR. WALL remarked that there are currently several different levels of care that are available for youths in the state that fall under that category, such as residential psychiatric treatment centers. He said that typically when a young person is sent out of state, he/she is not sent specifically for psychiatric care, but for complex behavioral health and medical issues, and he/she would go to a residential psychiatric treatment center. He stated that depending on the level of licensure in the laws of that state, the facility may or may not be a locked facility. He explained that Alaska has suffered from a lack of continuum of care and bed availability issues, but there are residential psychiatric treatment centers across the state and other children services as well. He said there is a good network of partners to work with, and the association that works with all of those is the Alaska Association of Homes for Children, which might be a good asset for answering questions as well.

2:51:32 PM

CHAIR CLAMAN announced that HB 290 would be held over for further review.

2:52:16 PM

**ADJOURNMENT**

There being no further business before the committee, the House Judiciary Standing Committee meeting was adjourned at 2:52 p.m.