

**ALASKA STATE LEGISLATURE
SENATE JUDICIARY STANDING COMMITTEE**

April 26, 2023

1:32 p.m.

MEMBERS PRESENT

Senator Matt Claman, Chair
Senator Jesse Kiehl, Vice Chair
Senator James Kaufman
Senator Cathy Giessel
Senator Löki Tobin

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

INFORMATIONAL HEARING ON DEPARTMENT OF JUSTICE INVESTIGATION OF THE STATE OF ALASKA'S BEHAVIORAL HEALTH SYSTEM FOR CHILDREN.

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

DR. ANNE ZINK, Chief Medical Officer
Department of Health
Anchorage, Alaska

POSITION STATEMENT: Contributed to the Informational Hearing on the Department of Justice Investigation of the State of Alaska's Behavioral Health System for Children.

HEATHER CARPENTER, Policy Advisor
Department of Health
Juneau, Alaska

POSITION STATEMENT: Contributed to the Informational Hearing on the Department of Justice Investigation of the State of Alaska's Behavioral Health System for Children.

FARINA BROWN, Acting Director
Division of Behavioral Health

Department of Health
Anchorage, Alaska

POSITION STATEMENT: Responded to committee member questions about behavioral health challenges in Alaska.

JEN GRIFFIS, representing self
Fairbanks, Alaska

POSITION STATEMENT: Delivered the presentation, Behavioral Health Systems of Care.

SHELLEY EBENAL, Chief Executive Officer
Foundation Health Partners
Fairbanks, Alaska

POSITION STATEMENT: Delivered the presentation, Interior Pediatric Behavioral Health Summit.

ACTION NARRATIVE

[1:32:18 PM](#)

CHAIR MATT CLAMAN called the Senate Judiciary Standing Committee meeting to order at 1:32 p.m. Present at the call to order were Senators Kaufman, Giessel, and Chair Claman. Senator Tobin arrived immediately thereafter and Senator Kiehl arrived during the course of the meeting.

INFORMATIONAL HEARING ON DEPARTMENT OF JUSTICE INVESTIGATION OF THE STATE OF ALASKA'S BEHAVIORAL HEALTH SYSTEM FOR CHILDREN.

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CHAIR CLAMAN announced the consideration of the Informational Hearing on Department of Justice Investigation of the State of Alaska's Behavioral Health System for Children.

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DR. ANNE ZINK, Chief Medical Officer, Department of Health, Anchorage, Alaska, offered the presentation titled "Alaska's Efforts to Improve Behavioral Health Outcomes for Children." She stated that the presentation will address the behavioral health needs for children in Alaska. She clarified that the foregoing was not the department's legal response to the Department of Justice.

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DR. ZINK began with slide 2, "Behavioral Health Funding." She stated that the Department of Justice focused on Medicaid

funding so the presentation would took but it was important to note that the four sources need to be thought of collectively.

Medicaid, grants, general fund expenditures, and other payers are the State's primary tools to support a broader range of services and provide Alaskans with access to services not typically covered by Medicaid.

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SENATOR GIESSEL asked if committee members should hold their questions until after the presentation.

DR. ZINK replied that their preference was to take questions after the presentation.

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HEATHER CARPENTER, Policy Advisor Department of Health, Juneau, Alaska, revisited slide 2, "Behavioral Health Funding." She reminded the committee that three funding structures exist under Medicaid in Alaska; these are the state plan and two waivers. The state plan provides the bulk of services for which Medicaid is paid; the 1915C home and community based service waivers are tailored to individuals who require an institutional-level of care; and the federal government's demonstration 1115 behavioral health waiver that is tailored to the whole system and allows the state to make wholesale changes, which brought in a new service array that allowed behavioral health services billable to Medicaid.

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MS. CARPENTER moved to slide 3, "Medicaid Behavioral Health Services in Alaska."

- Alaska is a Medicaid fee-for-service state.
- Alaska relies on non-government entities to provide most direct care services.
- Service availability depends on whether providers offer those services, and which payment mechanisms they accept.
- Rural geography and diffuse population centers pose significant challenges to the provision of behavioral health care services.

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MS. CARPENTER spoke to slide 4, "1115 Demonstration Waiver Improved Access to Behavioral Health Services."

Improvements:

- Allows state to cover services not typically covered by Medicaid.
- Expands Medicaid-covered services to include at risk Alaskans.
- Reduces reliance on late-stage crisis services.
- Emphasis on early-stage outreach, prevention, and intervention.
- Uses innovative services delivery systems.

Unrealized Benefits:

- The second part of the waiver went into full effect in May 2020 through emergency regulations, 2 months after the start of the pandemic.
- Utilization of all the 1115 waiver could only begin once reimbursement became available in May 2020.
- Benefits of the 1115 waiver are still being implemented by a growing number of providers.
- Plan submitted to CMS [Centers for Medicare & Medicaid Services] for waiver renewal February 27, 2023.

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DR. ZINK spoke to slide 5, "Three Key Focus Areas Going Forward."

- Medicaid Reimbursement Structure and Participation
- Expanding Methods of Service Delivery and Facility Types
- Establish and Expand Crisis Stabilization Services

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MS. CARPENTER spoke to slide 6, "Medicaid Reimbursement Structure and Participation."

- Increased Rates for 1115 Services.
- Increased Rates for Home and Community Based Services.
- Rebased Rates for Home and Community Based Services.
- Rebasing Rates for Community Behavioral Health Providers.

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MS. CARPENTER spoke to slide 7, "Expanding Methods of service Delivery and Facility Types."

- 1) Increase utilization of existing services.
- 2) Fully implement new telehealth statute and regulations.
- 3) Additional non-Medicaid efforts:
 - Psychiatric Emergency Services (PES) Program.
 - Broadband Task Force.
 - Stakeholder Engagement.
 - Provider Education.
- 4) Identify and address gaps in the continuum of care.
 - Fully implement HB 172, 1115 and other areas of effort.

DR. ZINK remarked that infrastructure dollars are tied to healthcare workforce dollars. She recommended utilizing every level available to ensure housing, broadband and telehealth services across the state. The Medicaid waivers require many different pieces to come together.

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DR. ZINK discussed slide 8, "Crisis Stabilization Services Reduce the Need for a Higher Level of Care."

- 1) Statewide crisis call center.
- 2) Centrally deployed, 24/7 mobile crisis teams.
- 3) 23-hour and short-term stabilization.

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MS. CARPENTER spoke to slide 9, "Supporting Alaskans Close to Home."

- 1) Today, there are 73 children on Medicaid receiving care out of state.
- 2) Since December 2020 (start of DOJ investigation), Alaska has reduced the number of children on Medicaid receiving care out of state by 25.5%.
- 3) Out of state care is an option of last resort.
- 4) Children placed out of state are closely monitored by dedicated staff to coordinate care and ensure facility compliance.

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DR. ZINK continued to slide 10, "Improving Complex Care Coordination." She reminded the committee that systems do not always meet the needs of the patient. She acknowledged that the

Department of Justice report did not include many heartbreaking stories about children wishing to be closer to home. She highlighted that the challenges brought forward in the report exist in the state and across the nation. She revealed that the Improving Complex Care Coordination project was initiated by the Department of Health and the Department of Family and Community Health Services. Residing within the project is the crisis response team, which is a multidisciplinary team that meets weekly to address patient needs.

DR. ZINK shared that the team reviewed three cases this week. She noted that one case involved a multitude of behavioral health clinicians, both in-state and out-of-state, with no unified plan for the child. The second case involved a patient in an inpatient psychiatric facility requiring discharge and three-on-one services. Numerous funding types were braided together to provide the three-on-one service type allowing the patient to move back into the community. The third case involved a series of payment structures without a mechanism to include room and board and behavioral health needs. The crisis response team addresses solutions to meet patient's needs today.

DR. ZINK revealed that the complex care advisory group addresses methods of improving the systems. She mentioned possible solutions such as payment systems or regulation changes that allow for data-driven and informed decisions about regulations, statutes and license types. Another collaboration includes the complex care advisory group that works with the state and a multitude of partners to participate in providing facilities and needed services. The teams look for real-time solutions and partner with external stakeholders to constantly reiterate and change Alaska's services. She noted that the efforts do not replace the Complex Care Collaborative or the multi-sector state coordination group.

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MS. CARPENTER spoke to slide 11, "Tribal Collaboration."

- Tribal collaboration is essential in addressing Alaska's behavioral health needs.
- Tribal Health Organizations (THO) are vital partners in providing services in their regions and communities.
- For many rural communities, THOs are the only Medicaid enrolled provider.
- DOH and DFCS have designated tribal liaison positions.

- Alaska Medicaid utilizes the Medicaid Tribal Task Force, Tribal Behavioral Health Directors, and Medicaid Tribal Consultation to partner with tribes.

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DR. ZINK discussed slide 12, "Near Term Efforts in Progress."

- Developing Infrastructure for Complex Care Coordination.
- Increase Utilization of Waivers.
- Increase Behavioral Health Infrastructure.
- Developing Workforce.
- Improving Provider Support

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DR. ZINK spoke to slide 13, "What's Next?"

- Initiate a steering committee to determine goals, recommended approach, and timeline, and outline necessary resources to develop statewide and regional plans.
- Focus on statewide and regional services.
- Draft plan will be shared publicly, welcome robust public comment statewide, and involve listening session in specific regions.
- Final plan be shared with the legislature and other governmental agencies.

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SENATOR GIESSEL referenced slide 2 and asked what percentage of behavioral health funding is derived from Medicaid.

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MS. CARPENTER replied that she would need to work with the other payers and follow up with the data. She noted that the departments lacked an all-payor claims database to track the percentage. She stated that Medicaid covered over one-third of Alaskans and a large portion of children.

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SENATOR GIESSEL commented that not every Medicaid beneficiary receives behavioral health services.

MS. CARPENTER agreed.

SENATOR GIESSEL asked about the challenges the department had with its computer data systems. She asked if those challenges were identified in the DOJ report.

MS. CARPENTER asked if she was referring to the eligibility system.

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SENATOR GIESSEL replied that she was referring to the payment system that is audited annually.

MS. CARPENTER responded that the department publicly acknowledged the challenges with the vendor Optum. She stated that the federal government did not identify that Optum was part of the problem, but instead highlighted the issue of too few providers delivering the necessary community services. She acknowledged that when providers are not paid in a timely manner, the stress leads to diminished service delivery. She remarked on the importance of paying providers in an accurate and timely manner. She stressed that the department was taking every step possible within the contractual process to hold Optum accountable.

SENATOR GIESSEL highlighted the errors the department makes when submitting claims to the federal government. She stated that the repayments identified in the audits were concerning.

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DR. ZINK agreed that the state must have transparent and reliable data sources. She added that the state employs two additional data sources: the Alaska Automated Information Management System (AKAIMS) and the Health Information Exchange (HIE). She stated that the department was making strides in streamlining and improving both data management systems. She highlighted the importance of data systems for enabling data-informed decisions. She asked Acting Director Brown if she had anything to add.

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FARINA BROWN, Acting Director, Division of Behavioral Health, Department of Health, Anchorage, Alaska, stated that the DOJ findings did identify the administrative services organization as an area requiring better administration and oversight of claims adjudication. She noted that the division continues to work with Optum on claims adjudication. She mentioned that the department was currently involved in a corrective action with Optum regarding the ongoing claims adjudication issues. She

acknowledged that the claims payments have contributed to the difficulty with providers offering services across the state. She recognized the criticality of the waiver's success and acknowledged that without remediation, slow growth would continue.

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SENATOR GIESSEL asked about slide 8, bullet 3, "23-hour and short-term stabilization." She expressed concern about patients reaching the end of the 23-hour stabilization period. She wondered about the next step for those people.

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CHAIR CLAMAN highlighted that Senator Giessel sponsored crisis stabilization legislation.

MS. CARPENTER agreed that legislation passed last year and in 2020 were heralded by both Senator Giessel and Senator Claman. Responding to Senator Giessel's query about the 23-hour stabilization period, she explained that if a person is not stabilized and continues to meet the criteria for the involuntary hold, they would be transferred to a short-term crisis residential center. For larger facilities, the next level of care is available on site. She highlighted that a lack of wraparound community services leads to a new chokepoint in the system. She stressed the need for a full-spectrum care continuum, so Alaskans are ensured behavioral health care as close to home as possible. The hope is for quick stabilization and discharge to community providers.

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SENATOR GIESSEL highlighted the importance of residential treatment and partial hospitalization options.

DR. ZINK shared that the state saw an increase in Designated Evaluation and Treatment (DET) facilities. She quoted national data stating that the 23-hour facilities will stabilize 70 percent of patients. She added that the 23-hour stabilization facilities can offer support for people discharged from API and requiring transitional care in rural areas.

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SENATOR GIESSEL stated that partial hospitalization is intended to provide programmatic day therapy.

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SENATOR TOBIN referred to the DOJ report that mentioned site visits in 2022. She asked about the inconsistencies noted on slide 4 with the 1115 waiver dictated by current data points. She pointed to the statement, "emphasis on early-stage outreach, prevention and intervention." She understood that the hope was to prevent the need for crisis services. She noted that the DOJ report mentions the school-based services and early community and home interventions. She wondered about the department's efforts related to accessible providers in schools. She wondered about preventative options. She highlighted the report's mention of cultural competency. She asked how the legislature could ensure that a cultural component was a key part of the effort.

2:09:03 PM

MS. CARPENTER responded that the departments have designated tribal liaisons in the commissioners' offices. Each division and department has tribal liaisons, and the culturally relevant care is of great importance. She added that tribal providers are often the only providers in the rural communities. She reminded the committee that the state is not a direct service provider.

MS. CARPENTER explained that delivering Medicaid services in schools is a complex issue. She noted that past audit findings led to federal repayments. She stated that the steering committee will address the issue of administering services in the schools. She added that the Centers for Medicare and Medicaid Services (CMS) has rules about services delivered in schools. She advocated for a collective approach to designing school-based Medicaid services. She highlighted the flexibility and options through SB 74. She mentioned the possibility of approaching the federal government for permission to offer school-based Medicaid services. She noted the challenges in obtaining, licensing, and housing new behavioral health providers. She deferred to Acting Director Brown for information about preventative services and efforts.

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MS. BROWN responded that the early components of care aspect of the waiver focus on the use of at-risk criteria. She stated that once an individual has to reach the threshold of severely mentally ill or severely emotionally disturbed, the behavioral health condition is deteriorating. She noted the essential aspect of ensuring that individuals can engage in waiver services and providers can be paid before an adult or youth reaches the threshold of Severe Mental Illness (SMI) or Severe Mental Disorders (SMD). She mentioned the addition of the service known as Home Based Family Treatment that allows for a

family to engage in services based on a social determinate of health that allows a provider to bill for services. The treatment plan strives to catch individuals upstream before symptoms cascade. She added that many state behavioral health providers derive a large percentage of revenue from school-based services. She informed the committee that school-based services are often billed on an outpatient fee-for-service continuum. The billing mechanism does not allow the state to publish concrete data about the revenue Alaskan providers receive.

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MS. BROWN responded to the query about cultural relevance. She remarked that the department requires all services to be culturally relevant. The waiver requires continuing education to meet the culturally relevant criteria for qualified addiction professionals. She added that providers must meet the Substance Abuse and Mental Health Services (SAMHSA) guidelines, which include being culturally relevant and influenced.

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SENATOR TOBIN expressed appreciation for the attention to cultural relevance. She reported reading Alaska Native elder literature stating that young people require education that respects all components of their psyche, including their spirit, language, and food. She requested more data related to slide 9, indicating that 73 children are receiving services via Medicaid outside the state. She wondered about past data points related to children who are receiving Medicaid services out of state.

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CHAIR CLAMAN requested the data going back to 2014.

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MS. CARPENTER offered to provide the data points. She highlighted that before the Bring the Kids Home initiative in 2004, there were 965 kids that were out of state. Reducing that number to 73 shows the work the department has put into this over the last 20 years.

DR. ZINK offered to provide detailed information about the 1115 grant waiver. She also described the new Office of School Health and Safety and Office of Healthy and Equitable Communities. The latter recognizes the varying cultural needs in different regions.

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SENATOR KIEHL joined the meeting.

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CHAIR CLAMAN referenced the official response to the Department of Justice letter. He commented on the reality of the decision Alaska made years ago to contract out almost every feature of behavioral health coverage. He observed that absent massive investment to bring more of these services in-house, the state has to rely on outside entities to provide these services. In connection with that, he mentioned the criticisms related to Medicare and Medicaid rates. He asked if the state has the same issues getting providers for Medicaid that it has getting providers who will accept Medicare.

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MS. CARPENTER stated that rates are a complex art. She advised that in Alaska, Medicaid does pay more than Medicare. Another consideration is that the host of services the department offers are subject to Centers for Medicare & Medicaid Services (CMS) upper payment limits. What this means is that when somebody is facing an upper payment limit, it's necessary to prove to CMS that the payment isn't actually above Medicare. Most individuals do not understand the nuance and that the state has to oftentimes pay lower than Medicare.

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DR. ZINK highlighted that rates are important, but there are many different factors related to providing services within a state. Providers need to be connected to specialty services but they also need a volume of kids that they serve regularly. Further, the payment systems between private insurance and Medicaid need to align enough that similar care can be provided day-to-day so the payer type doesn't become an issue.

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CHAIR CLAMAN referred to the official response to the Department of Justice (DOJ). He asked whether there would be a plan with a more specific focus on children.

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DR. ZINK replied that the vision to address the DOJ report is for children and behavioral health services. The hope is to build on that to provide support for physical, mental, social, and cultural health. The department is talking with other regional workers about how they can help support this effort.

CHAIR CLAMAN commented that children can often get lost when there are larger numbers of adults.

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SENATOR GIESSEL referenced Ms. Brown's statement about the difficulty parsing out who was getting care in school-based services. She asked whether there was a specific code for that.

MS. BROWN replied that school based services are distinct but do not represent the full continuum of behavioral health services being provided in schools. There is the nuance between using place of service school and place of service 99, and DBH is working with providers to ensure proper coding.

SENATOR GIESSEL underscored the importance of school funding so these venues are available for children to receive these services.

CHAIR CLAMAN invited Jen Griffis to offer her perspective as a parent with a child in the system.

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JEN GRIFFIS, representing self, Fairbanks, Alaska, delivered the presentation, "Behavioral Health Systems of Care, A Parent's Perspective." She explained that she adopted two girls from the foster care system and that one of her daughters had behavioral problems. By the time her daughter was six years old, the behavioral problems began to eclipse her parenting abilities. She stated that her husband was a physician, and she was an educator, so they understood systems and research. Even though they had money and privilege, they were unable to find appropriate and available services. She and her husband were concerned for the family's safety. After months without answers, they landed on in-patient hospitalization as the only option. They drove three hours to the nearest pediatric psychiatric hospital and left their six-year-old daughter with strangers. She noted that the hospitalization in 2012 was followed by two more over the next six weeks. She tried piecing together support options and attempted a therapeutic home setting, but intensive community services were lacking statewide. After multiple treatment failures, the family sought residential treatment options. Following placement in residential treatment, the family worked with the case management team to transition her daughter back into the community. This was never successful; her daughter's intense level of needs did not match the available community services. The lack of residential treatment options meant that she grew up in multiple facilities in multiple states over several years.

MS. GRIFFIS informed the committee that she served as a parent representative for the plaintiff's mediation team during a lawsuit in Idaho, fighting for better mental health options for children in the state. She participated in mediation meetings for over a year before transitioning into the settlement agreement with planning and implementation of the new children's behavioral health system. She continued to support various aspects of the implementation for the next eight years.

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MS. GRIFFIS stated that during her time advocating for the new system, her family continued to struggle to access the right level of services for their daughter. She experienced the impacts of the system she was advocating to change. She expressed pride in her efforts to infuse the parent voice in every aspect of the children's behavioral health system in Idaho. She noted that other parents' words, ideas, and experiences were central to the planning, design, and evaluation of the system. She offered to provide the committee with greater context for systems of care and thoughtful recommendations related to the planning process in Alaska.

[2:33:00 PM](#)

MS. GRIFFIS spoke to the slide titled, "What is a System of Care."

- Term "system of care" was first used by Stroul and Friedman in 1986
- Core values of a System of Care
 - Family-driven and youth-guided
 - Community-based
 - Culturally and linguistically competent
- Guiding principles for a System of Care
 - broad-base of services, individualized, least restrictive, family/youth engagement, cross-system collaboration, care management, developmentally appropriate, transition-age supports, prevention, continuous quality improvement, protects individual rights, non-discriminatory

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MS. GRIFFIS continued to the slide "System of Care Implementation."

- Challenges:
 - Unequal implementation across states

- o Limited access to community-based services in certain populations
 - children with a higher-level of need
 - families in rural communities
- Result:
 - o Investigations and lawsuits across the country related to a lack of community-based services and continued reliance on residential treatment

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MS. GRIFFIS spoke to the slide "Alaska's Strengths."

- Medicaid waivers
- Relationships with tribal partners and other stakeholders
- State-level legislation
 - crisis intervention
 - telehealth opportunities

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MS. GRIFFIS spoke to the slide "Lessons from Other States."

- Parents and youth should be equal partners, at the treatment level and at the system level.
- Medicaid is a funding source, not a system design.
- Person-centered data tells stories and transforms systems.

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MS. GRIFFIS spoke to the ripple effect of stories when services are not available. When the right level of care is available at the right time, the ripple effects can be success in education, positive relationships, and goals for the future. She stressed the need for collaboration and intention to transform children's mental health systems.

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SENATOR TOBIN emphasized the importance of qualitative data because focusing solely on quantitative data misses the stories.

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SENATOR GIESSEL applauded the speaker.

CHAIR CLAMAN thanked Ms. Griffis for highlighting that this is very person-based and it's a reminder that children are the state's greatest resource.

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CHAIR CLAMAN moved to the next presenter and explained that Shelley Ebenal was invited because the hospital's capital request focuses on providing mental health services for children.

[2:43:24 PM](#)

SHELLEY EBENAL, CEO, Foundation Health Partners (FHP), Fairbanks, Alaska, delivered the presentation, "Fairbanks Memorial Hospital Inpatient Behavioral Health Expansion Proposal." She advised that FHP operates Fairbanks Memorial Hospital, Denali Center, and Tanana Valley Clinic. She relayed that the Department of Justice investigation was a new twist on an old problem. She reinforced that the heart of the problem is that children are in crisis.

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MS. EBENAL displayed slide 2 which shows the logos for the 56 participants in the Interior Pediatric Behavioral Health Summit.

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MS. EBENAL moved to slide 3, "Visualizing Gaps in Our Continuum of Care." The graphic provides a visual of the gaps in the existing continuum of care in the Interior. It shows substantial gaps in residential and stabilization treatment for children. She relayed that FHP was proposing an adolescent behavioral health unit and the expansion of the adult unit. State funding is required for this expansion.

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MS. EBENAL reviewed slide 5, "Capital Request Summary."

Capital Construction Expense: \$5,400,000

\$3.4 Million	State Capital Request
\$1.0 Million	Alaska Mental Health Trust Capital Request
<u>\$1.0 Million</u>	Rasmuson Foundation Capital Request
\$5.4 Million	

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MS. EBENAL spoke to slide 6, "Pediatric Service Gap."

Every day we are boarding pediatric behavioral health patients in the Emergency Department (ED).

- The average length of stay for these patients is 114.94 hours.
- Emergency Departments are not conducive environments for appropriate evaluation and psychiatric treatment of children or adults.
- Almost all of these patients would qualify for treatment in a pediatric inpatient unit and avoid transfer outside of the community or State.
- There is no adolescent inpatient psychiatric care for the children in Interior and Northern Alaska.

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MS. EBENAL continued to slide 7, "Pediatric Service Gap Continued."

FMH sees about 350 unique pediatric patients for a primary behavioral health reason each year who need multiple days of care. Patients stay in the emergency department as our case managers search for appropriate treatment placement outside of Fairbanks.

Almost all of these patients would qualify for adolescent inpatient behavioral health care. **FHP estimates that each patient's inpatient stay would be 4-7 days, creating an average daily census of a minimum of 3.8 patients per day.** That means our unit would be at capacity every day of the year. Creating this access to inpatient care within Northern Alaska and Interior Alaska would give relief to a region that doesn't currently have options for pediatric patients.

Capital funding will allow reconstruction of existing space following strict and expensive Federal Guidelines for a four-bed child psychiatric unit within Fairbanks Memorial Hospital.

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MS. EBENAL moved to slide 8, "Emergency Department Seclusion Room." She acknowledged that the picture of the exclusion room should disturb everyone. It's a rubber room without amenities where the individual is physically safe until they can be placed appropriately. A psychiatrist once described the room as the place where children are warehoused until they can be placed.

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MS. EBENAL spoke to slide 9, "Adult Service Gap."

The current makeup of the FMH adult inpatient Behavioral Health Unit (BHU) is located on the 4th Floor at FMH. It consists of 20 inpatient beds; four beds provide intensive care and sixteen beds provide intermediate care.

- Over the last three years, the acuity of our adult behavioral health patients has continued to escalate.
- More patients require admission to the intensive unit, prior to moving out to the intermediate unit.
- Due to limited beds in the intensive unit, more adult patients must remain in the emergency department without full treatment while awaiting placement in the appropriate location.
- We are also often unable to accommodate acute patient transfers from other locations due to our space limitations.

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MS. EBENAL continued to slide 10, "Adult Service Gap Continued." It includes a line graph that shows the average daily census for the Intermediate Behavioral Health Unit in blue and the Intensive Behavioral Health Unit in red.

The proposal is to add 2 additional acute care rooms to the 4 room intensive care unit for a total of 6 rooms to meet the adult treatment needs.

When an adult patient meets the criteria for admission, they are transferred by the emergency department to the behavioral health unit. The average census by month in 2022 for the behavioral health unit was 12.2, but in some months, it was as high as 15. That is taxing on our 20-bed unit, especially when only 4 of those beds can accommodate patients needing higher acuity care.

The blue line represents patients in the intermediate unit. The red line represents patients in the intensive unit. These two numbers together represent the average daily census for the behavioral health unit (BHU).

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MS. EBENAL discussed slide 11, "Facility Upgrade Proposal." The approximate capital expense is \$5.4 million. It shows the floor plans for the proposed pediatric inpatient unit with low and high acuity care areas.

She highlighted that the solution for the current situation has to involve both the state and communities. The challenges are considerable. FHP could open a new unit right now, but wouldn't be able to staff it. The proposal is to build a four-bed unit next to the inpatient unit so resources can be shared. Psychiatrists on staff are board certified for child psychiatry. The proposal is also for two more acute beds to take the pressure off the Emergency Department.

MS. EBENAL thanked the state and administration for helping from an operational perspective and expressed hope that capital help would also be forthcoming.

SENATOR GIESSEL commented that the information in the last two presentations moved the committee. She stated that the finance committee was working hard to restrain the size of the dividend, which would make it possible for these kinds of improvements and delivery of services. Everyone would benefit.

CHAIR CLAMAN stated that he had no intention of supplanting the role of the finance committee in making such decisions, but the Fairbanks presentation in particular highlights a plan for the long term. He agreed with Senator Giessel's comments about where the state is spending its money.

2:53:31 PM

There being no further business to come before the committee, Chair Claman adjourned the Senate Judiciary Standing Committee meeting at 2:53 p.m.