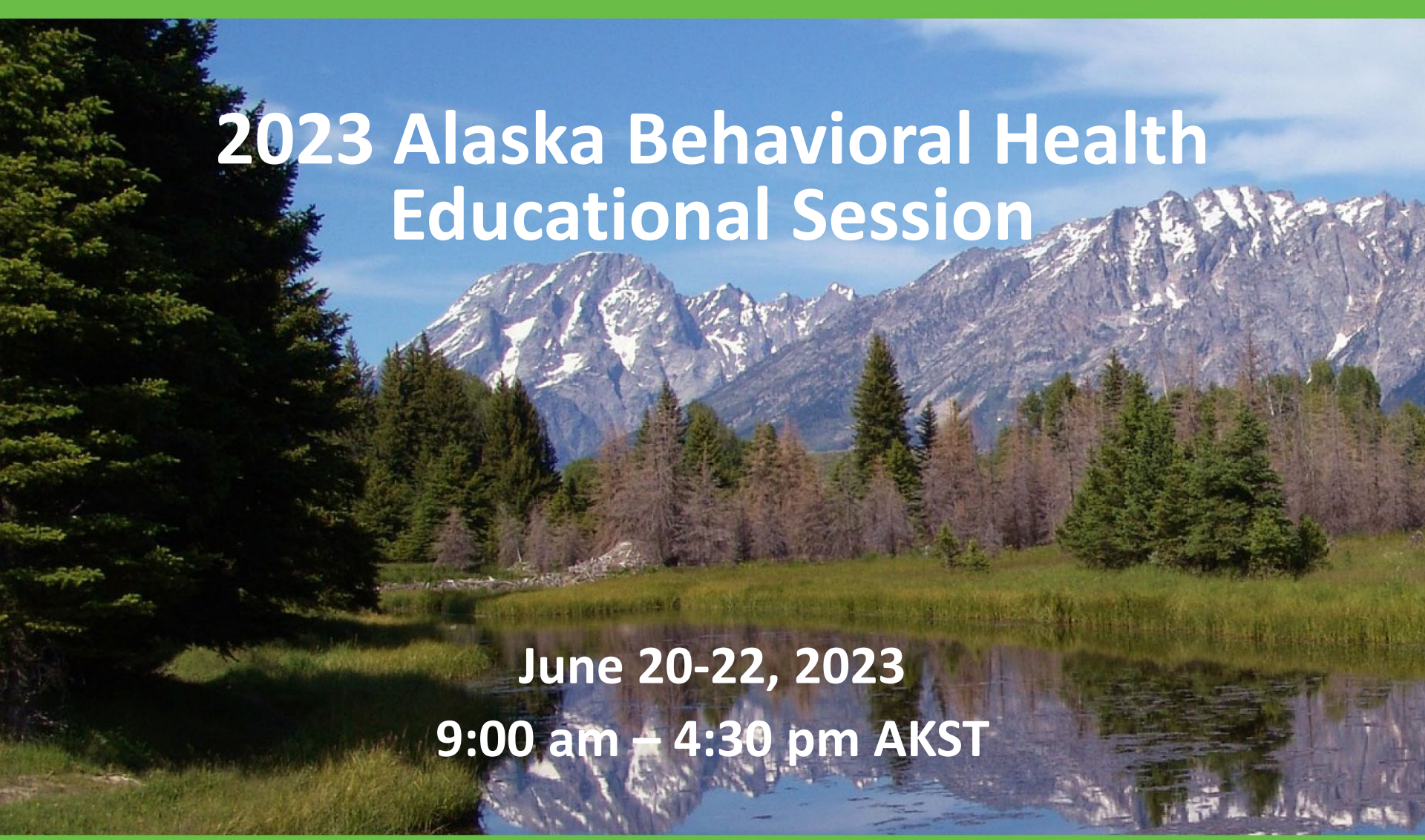


2023 Alaska Behavioral Health Educational Session

June 20-22, 2023

9:00 am – 4:30 pm AKST

Comagine Health

Comagine Health

Welcome and Introduction

Yvette Stratton, RN, BSN, CCM
Executive Director, Care Management

Welcome to Forging Partnerships to Provide Optimum Behavioral Health Services for Alaska's Youth

Approved Provider Statements:

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, this activity has been planned and implemented by Alaska Native Medical Center (ANMC) and UAA Alaska Center for Rural Health and Health Workforce - Alaska's AHEC. ANMC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

CPE Credit will be posted to the online CPE Monitor system within 60 days following completion of each activity when applicable.

Contact Hours:

ANMC designates this activity for a maximum of 11.75 contact hours, commensurate with participation.

Financial Disclosures:

None of the presenters and planners for this educational activity have any relevant relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Requirements for Successful Completion:

To receive CE credit please make sure your attendance is recorded, actively engaged in the entire activity, and completed the course evaluation form.

For more information contact
jlfielder@anthc.org or (907) 229-1185

ALASKA NATIVE MEDICAL CENTER

Comagine Health

Keynote Speaker
State of Alaska Updates

Shauna Credit, MS, MA, RHIA

Medicaid Section Manager, State of Alaska Division of Behavioral Health

Comagine Health

Behavioral Health Professionals Working with Children and Adolescents

Brandy Stratman, LCSW

Clinical Supervisor, Residential Treatment Program
Provider Adolescence

SELF- REGULATION STRATEGIES FOR BEHAVIORAL HEALTH PROFESSIONALS WORKING WITH CHILDREN AND ADOLESCENTS

Presented By: Brandy Stratman, LCSW
Providence Adolescent Residential Treatment Program

"In my experience, healthily vulnerable people use every occasion to expand, change, and grow."

-Fr. Richard Rohr



Building Blocks for Resiliency

- Self-Awareness –What is happening around me? Who am I? How do I impact others?
- Self-Regulation – How do I feel? What do I do with my feelings?
- Purpose- Am I connected to something bigger?
- Connection – Where? With who? How?

Self-regulation

- Behaviorally: Self-regulation is the ability to act in your long-term best interest, consistent with your deepest values.

- Emotionally: Self-regulation is the ability to calm yourself down when you're upset and comfort yourself up when you're experiencing a big emotion.

- Mentally: Self-regulation allows you to know you are enough.

Emotional Regulation

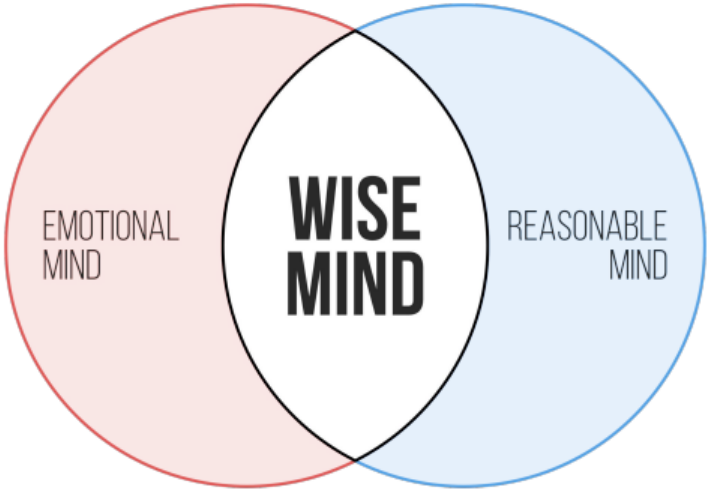
- Regulation is not about getting rid of an uncomfortable feeling.
- It is the ability to be WITH an uncomfortable feeling and still be OK.



"All behavior is an attempt at regulation." — Lisa Dion

Emotional Regulation

Regulated State



Marsha Linehan Ph.D. — DBT

Emotional Regulation- Mirror Neurons

- **We instinctively regulate through one another using the mirror neuron system.**
- **Our children set us up to feel how we feel so that they can learn through us how to regulate. — Lisa Dion calls this "the set-up" in Synergetic Play Therapy**
- "We are hard-wired to perceive the mind of another being." — Dr. Dan Siegel

Emotional Regulation
School-age kids (5-12)

- Dysregulation looks like arguing, resisting, shutting down, aggression with peers or family members, nervousness, refusal, anxious….



Emotional Regulation Teens

Their brains are going through rapid growth and intense self-actualization.

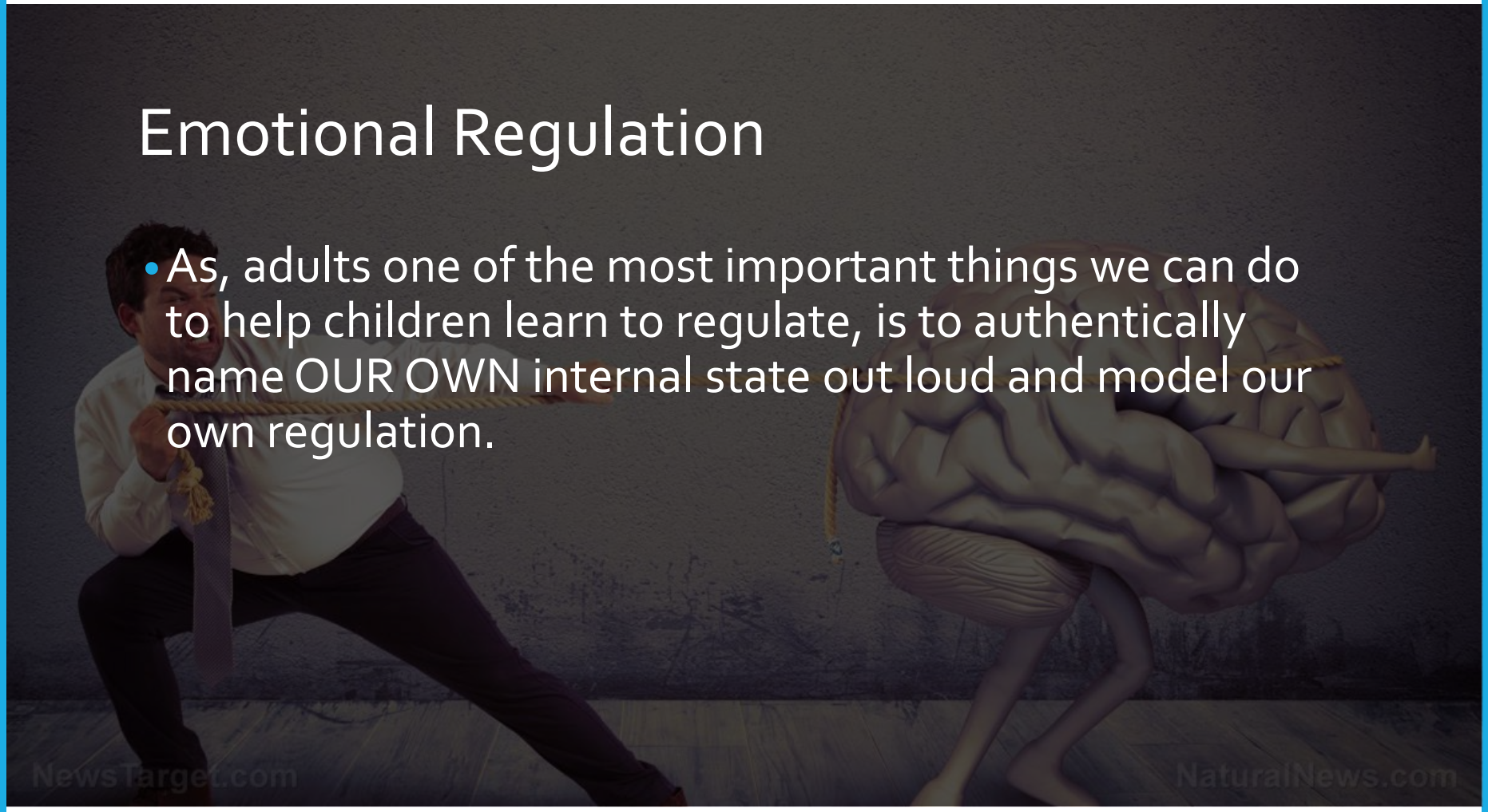
Dysregulation might look like refusing to engage, risky behavior, arguing with authority/picking fights, physical aggression, fears, depressive withdrawn behavior, etc…

We often get stuck in the loop of reasoning with teens because they are practicing with us as their prefrontal cortex rapidly grows.



Emotional Regulation

- As, adults one of the most important things we can do to help children learn to regulate, is to authentically name OUR OWN internal state out loud and model our own regulation.



What Blocks Self- Regulation?

- Avoid looking within
- Lack of awareness of our body
- Viewing stress negatively
- Numbing
- Victim stance
- Blame
- Isolation
- Lack of trust
- Reliance on aligning negatively to self soothe.

“I AM ENOUGH”

What is a trigger?

- An event, conversation, or action that sets off an emotional reaction and often is attached to some unresolved issue.
- Something that engages your sympathetic nervous system and decreases your ability to be curious, creative or calm
- We are not in alignment with our values when we are triggered

Threat response

Physiological response

- Fear
- Anger
- Dissociation
- Sweating
- Heart beat over 100
- Energy

Response behavior

- Defensive
- Avoidant
- Irritable
- Demanding
- Short
- Dismissive
- Mute

Armor

- Judgment
- Blame
- Disconnection
- Command & Demand leadership
- Reactivity
- Irritability
- Shutting down



Connection & Communication

Passive	Passive Aggressive	Aggressive	Assertive
Avoiding Giving up Lacking confidence Shutting down Pretending to agree Saying nothing Personalization	Sarcasm Ignoring Off-handed comments Defensiveness Making jokes about others or the situation	Dominating Talking more Arguing Pushing Controlling "You" statements	Direct communication Clear messages "I" statements Fair compromises Respectful Speak the truth Compassion Curiosity

Why do we need self-regulation?

Regulated	Dysregulated
Maximal cognitive & motor function	Limited access to prefrontal cortex
Intentional	Reactive
Creative problem solving	Repeat mistakes
Connected & communicative	Coercive or avoidant

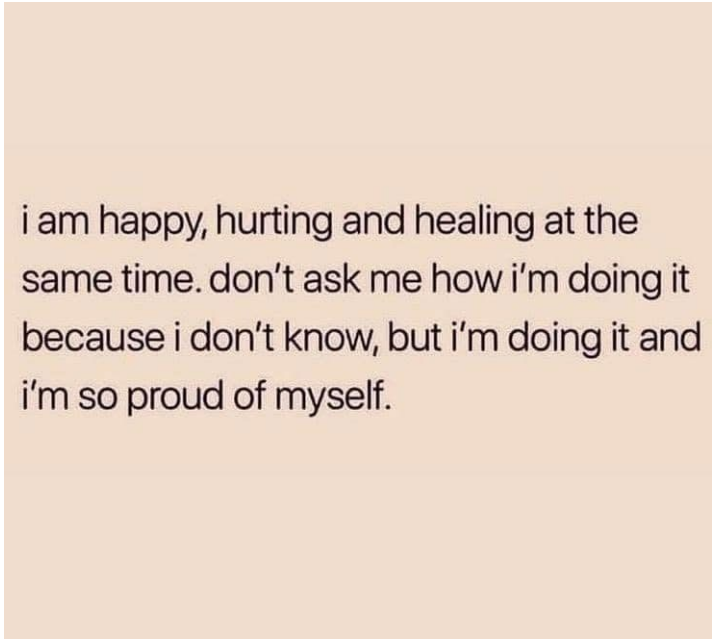
Self-regulation tools

- **Breathe:** Increase access to parasympathetic nervous system
- **Movement:** Shift your body from defensive to open. Shift your body from fear to strength.
- **Awareness**: Thoughts, feelings, sensations, expectations
- **Scan for Good**: Measuring the success of your interactions with others on your own engagement rather than only the outcome of the treatment
- **Connection**: Turn toward what is deeply human in each interaction with students and with support system

PRACTICING SELF-REGULATION AT WORK

T

Self-compassion



Scanning for the good

Daily practice

- How have a helped my clients today?
- When have I advocated for something I believe in?
- When have I engaged in self-care effectively?
- Who have I provided support?

Weekly personal practice

- Who is helping me?
- Who listens to me?
- What was something good that happened today?

Practice

Answer three of the "scanning for the good" questions and then share with the group one of your answers.

Talk with the group about how it felt to scan for the good.



"We'd like to believe that there are two kinds of people in the world – those who need help and those who offer help.

The truth is that we are both. We need to give and we need to need."

-The Compassion Collective

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Break

Back in 20 minutes

Comagine Health

Crisis Now Program Updates and Initiatives

Eric Boyer, MPH

Senior Program Officer, Alaska Mental Health Trust Authority

Crisis Now/Behavioral Health Crisis System Implementation across Alaska

Eric Boyer, Senior Program Officer

Trust
Alaska Mental Health Trust Authority

Alaska Medicaid Behavioral Health Provider Conference

June 20, 2023

CRISIS NOW

Why Crisis Now?

Physical Health Emergency



Behavioral Health Emergency



Essential Principles & Practices

Recovery Oriented -- Significant Role for Peers -- Trauma-Informed Care -- Zero Suicide/Suicide Safer Care -- Safety and Security for People in Crisis -- Crisis Response Partnerships

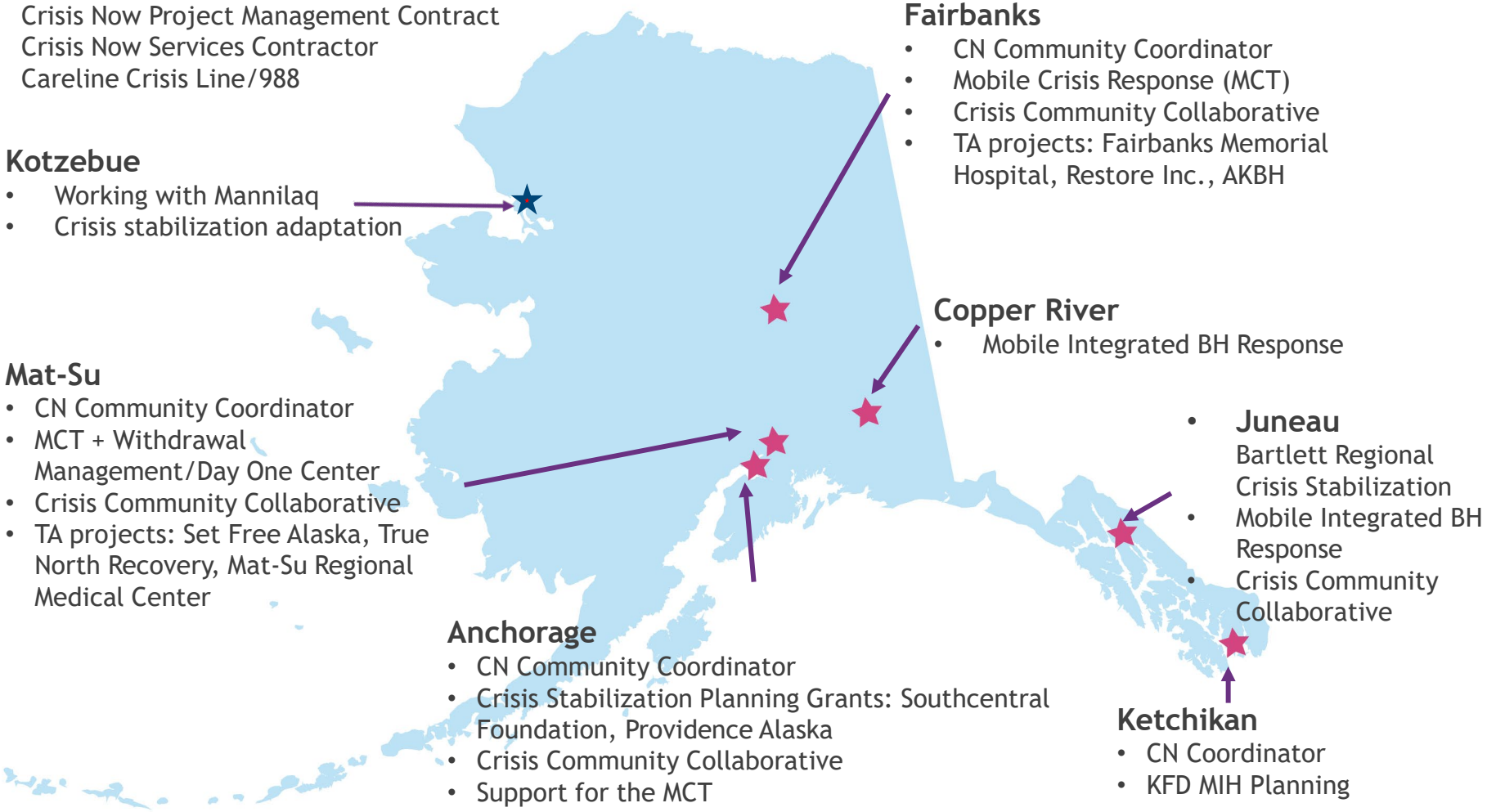
Implementation Workplan: updated monthly

Core Areas for Implementation, 2020 – 2023

- Project Management and Stakeholder Communication
- Systems Development and Coordination
- Crisis Call Center Development
- Community Coordination
- Mobile Crisis Response
- 23-hour/short term crisis stabilization

Workplan includes goals, objectives, lead and support entities and timeframe, all tied to the recommendations in the 2019 RI Alaska Consultation Report.

Trust/SOA/Agency Investments



Statewide
- Crisis Now Project Management Contract
- Crisis Now Services Contractor
- Careline Crisis Line/988

Kotzebue
- Working with Mannilaq
- Crisis stabilization adaptation

Fairbanks
- CN Community Coordinator
- Mobile Crisis Response (MCT)
- Crisis Community Collaborative
- TA projects: Fairbanks Memorial Hospital, Restore Inc., AKBH

Copper River
- Mobile Integrated BH Response

Mat-Su
- CN Community Coordinator
- MCT + Withdrawal Management/Day One Center
- Crisis Community Collaborative
- TA projects: Set Free Alaska, True North Recovery, Mat-Su Regional Medical Center

Juneau
- Bartlett Regional Crisis Stabilization
- Mobile Integrated BH Response
- Crisis Community Collaborative

Anchorage
- CN Community Coordinator
- Crisis Stabilization Planning Grants: Southcentral Foundation, Providence Alaska
- Crisis Community Collaborative
- Support for the MCT

Ketchikan
- CN Coordinator
- KFD MIH Planning

Community Adaptations







Community	Call Center*	Mobile Crisis	23-Hour	Short-Term	DET Unit?
Anchorage	911 transfers calls to Careline	Clinician + EMT/paramedic *	No Wrong Door (Providence and SCF)	Providence and SCF	API
Fairbanks	911 transfers calls to Careline	Clinician + Peer *	Voluntary only	Voluntary only	Yes
Juneau	Currently working on 911 transfer plan	Community Paramedicine model-currently	Voluntary and NED, no rejection	Voluntary only; youth and adults	Yes
Ketchikan	Planning Stages	TBD, MIH-type model	Planning	TBD	No
Mat-Su	911 transfers calls to Careline	Clinician + Peer *	Peer living room model-Voluntary	Voluntary only	Yes

Careline does not provide MCT dispatch in any communities to date. Where MCTs exist, 911 dispatches those teams.

Key:

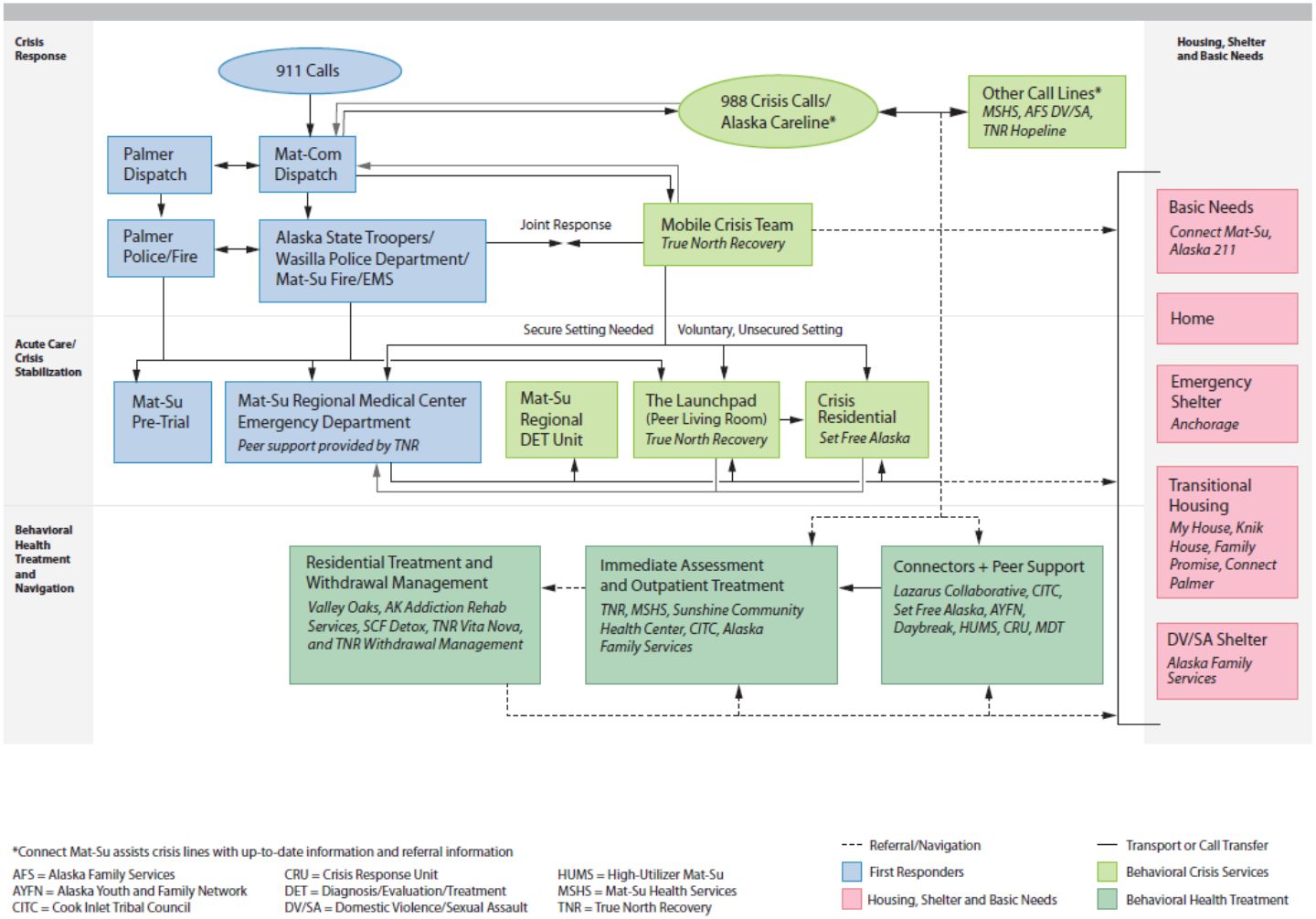
Green text = operational

Black- in process

*= Full alignment with Crisis Now framework requirements

Phase 1: Mat-Su Behavioral Health Crisis System

Phase 1 Mat-Su Behavioral Health Crisis System

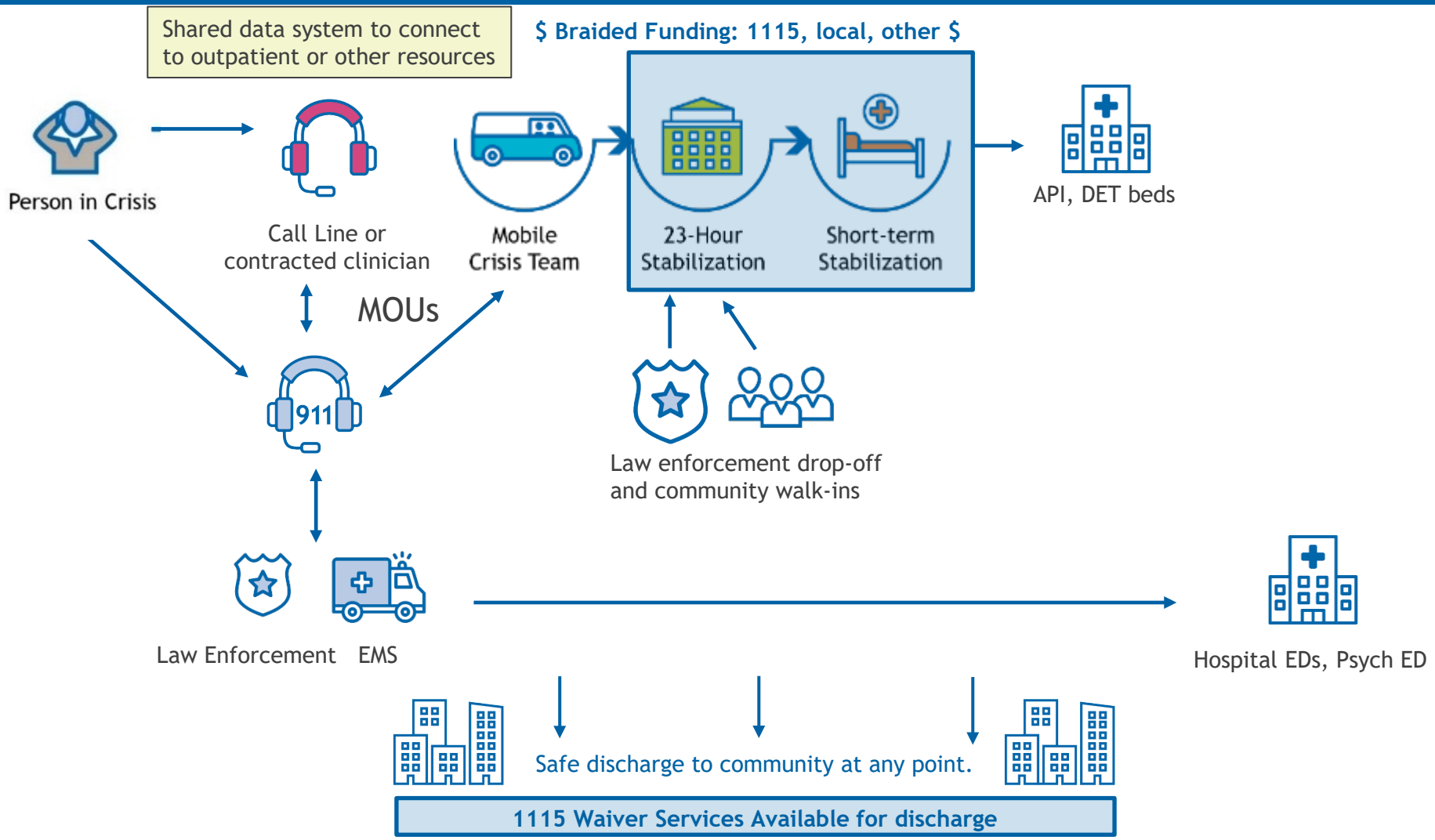


*Connect Mat-Su assists crisis lines with up-to-date information and referral information

AFS = Alaska Family Services
AYFN = Alaska Youth and Family Network
CITC = Cook Inlet Tribal Council
CRU = Crisis Response Unit
DET = Diagnosis/Evaluation/Treatment
DV/SA = Domestic Violence/Sexual Assault
HUMS = High-Utilizer Mat-Su
MSHS = Mat-Su Health Services
TNR = True North Recovery

Referral/Navigation
Transport or Call Transfer
First Responders
Behavioral Crisis Services
Housing, Shelter and Basic Needs
Behavioral Health Treatment

Phase 2: *Crisis Now* 23-hour + short term stabilization available



Funding Coordination, Contract Management, System Oversight + Performance Management **(LOCAL)**

Implementation: Next Steps

Anchorage

- Continued monthly meetings of core crisis providers, quarterly meetings with larger community providers, planning for care coordination/case conferencing group
- Providence and SCF Crisis Stabilization Phase II: Ramp Up/Launch

Mat-Su:

- Ongoing workgroup meetings organized around key topic areas: Dispatch and response, post-crisis connectors and other crisis providers

Fairbanks:

- Community mapping underway, continuing to build connectivity between providers
- Seeking solutions/operators for crisis stabilization
- MCT collaborative with Alaska State Troopers

Juneau: Initial community-level workgroup kick-off January 2022

Ketchikan: Community workgroup and planning underway

Kotzebue + Copper Basin: Initial planning underway.

Statewide: Call Center – enhancements for care traffic control

Questions

Comagine Health

Lunch Break

Back in one hour

Comagine Health

Adolescent Behavioral Health Improvement Projects

Elizabeth King, MPH

Director, Behavioral Health and Workforce, Alaska Hospital and Healthcare Association

Addressing the Continuum of Adolescent Behavioral Healthcare in Alaska

Comagine
Behavioral Health Summit

Tuesday, June 20, 2023

ALASKA
HOSPITAL &
HEALTHCARE
ASSOCIATION

Behavioral Healthcare is not a new problem

"Mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single condition."

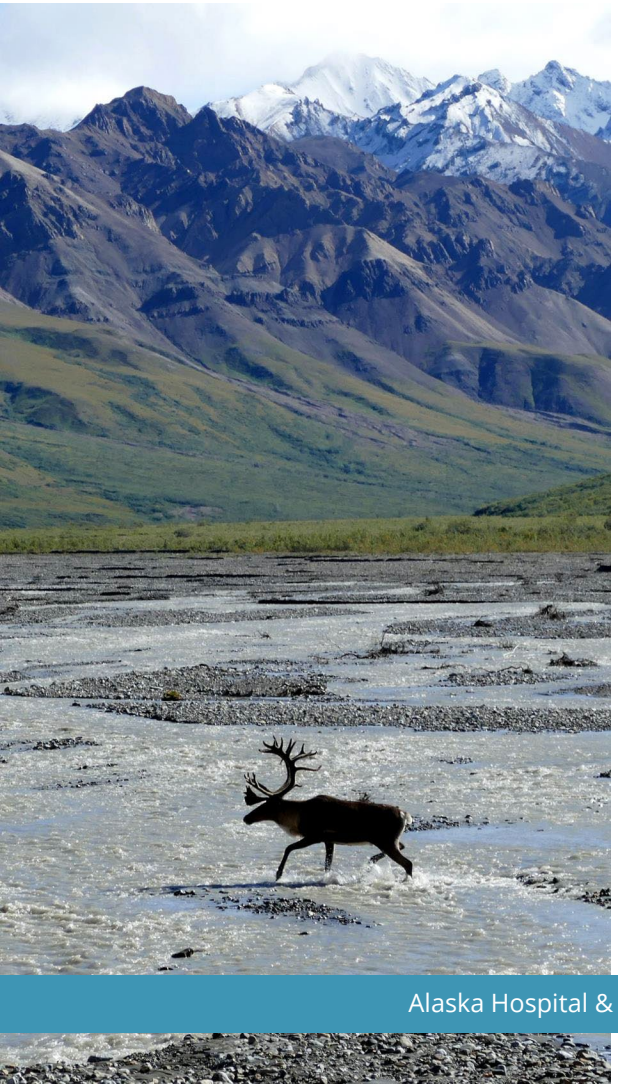
- *President John F. Kennedy, Special Message to Congress February 5, 1963*

Behavioral Healthcare is a continuing problem

"The mental health crisis in our nation is real – especially for our young people. We are paying a heavy price in lives lost and harmed."

- *Dr. Vivek Murthy, US Surgeon General*

June 27, 2022



Background information – Setting the Stage

- National setting
- The Child & Adolescent Project
- Alaska Data
- Findings from this work
- Next steps

Raising the alarm on a national level

U.S. Surgeon General's Advisory on Youth Mental Health

- "In 2019, 1 in 3 high school students and half of female students reported persistent feelings of sadness or hopelessness, an overall increase of 40% from 2009."

American Academy of Pediatrics Declaration of a National Emergency in Child and Adolescent Mental Health

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

White House Fact Sheet: Strategy to Address Our National Mental Health Crisis

- "Our youth have been particularly impacted as losses from COVID and disruptions in routines and relationships have led to increased social isolation, anxiety and learning loss. More than 50% of parents express concern over their children's mental well-being."

Child & Adolescent Access to Behavioral Healthcare

- Of the estimated 7.7 million children in the US with a mental health disorder – half received treatment from a MH professional.

- There are widespread shortages across the BH workforce and particularly among pediatric BH providers. *(National Governors Association.org)*

- Pediatricians are increasingly expected to treat their patients' mental health needs but do not feel well prepared to address those needs. Payment structures and unclear pathways for integrated services are barriers. *(American Academy of Pediatrics)*

Pediatric Boarding in Emergency Departments is Worsening Due to COVID-19

- COVID-19 has **"turbo charged"** the behavioral health crisis
  - In 2020, the proportion of mental health-related ED visits increased 24% for children ages 5 to 11 and 31% for those ages 12 to 17 compared to pre-COVID-19 levels.
  - In early 2021, ED visits for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same period i early 2019.
- 2022 saw increased acuity of BH patients accessing care in hospital settings
- Most severe for youth with:
  - Substance use disorders;
  - Intellectual and developmental disabilities and autism;
  - Eating disorders;
  - History of physical and/or sexual aggression;
  - Justice involvement
  - LGBTQ



For Some Teens, It's Been a Year of Anxiety and Trips to the E.R.

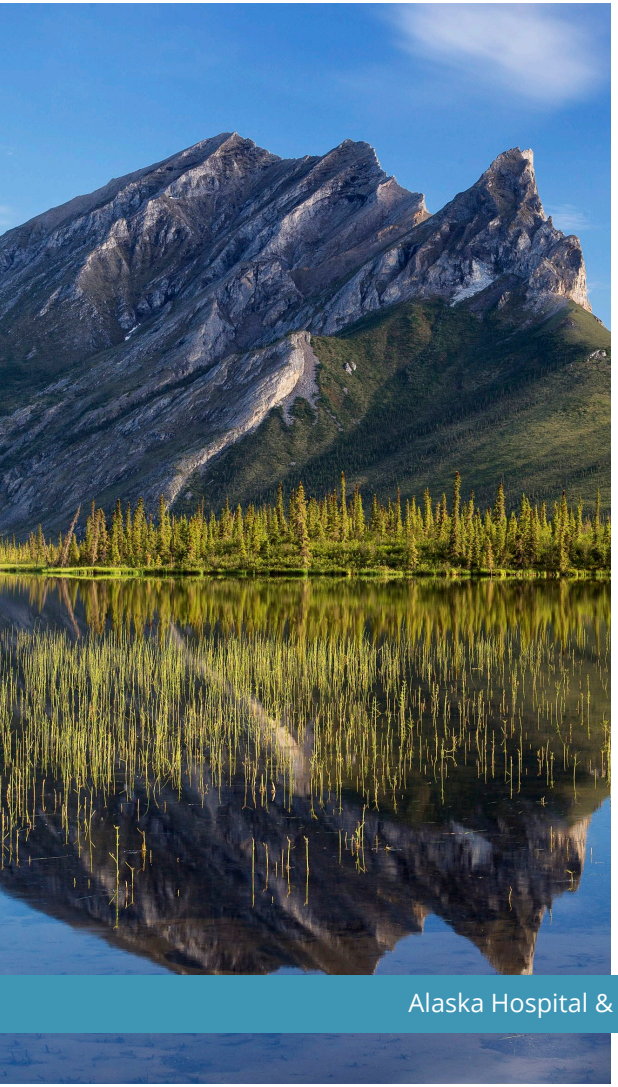
During the pandemic, suicidal thinking is up. And families find that hospitals can't handle adolescents in crisis.

Local

Psychiatric patients wait in ERs for days and weeks as inpatient beds are scaled back

Pandemic Has U.S. Hospitals Overwhelmed With Teens in Mental Crisis

U.S.News



Child & Adolescent Behavioral Health Improvement Project –

AHHA, supported by the Alaska Mental Health Trust Authority, launched a multifaceted planning effort to systematically describe the continuum of care, and identify actionable steps to **improve behavioral health care for children and adolescents.**

AHHA contracted with Agnew::Beck to support the stakeholder process, data analysis and document results.

Project Characteristics

- Participants- 117
- Organizations or facilities - 75

Timeline and Meetings

- Workgroup met monthly, March – June 2022
- Key informant interviews, June – August 2022
- Focus groups with outpatient, residential and hospital providers, July – August 2022
- Workgroup reconvening and strategy prioritization, September – November 2022
- Final recommendations report, January 2023

Project Goals and Scope

- Develop multi-level solutions to ensure individuals receive proper treatment in appropriate settings.
- Identify strategies to intervene before children and adolescents present to emergency departments.
- Incorporate the voices and perspectives of caregivers and adolescents with lived experience navigating the acute behavioral health system of care.

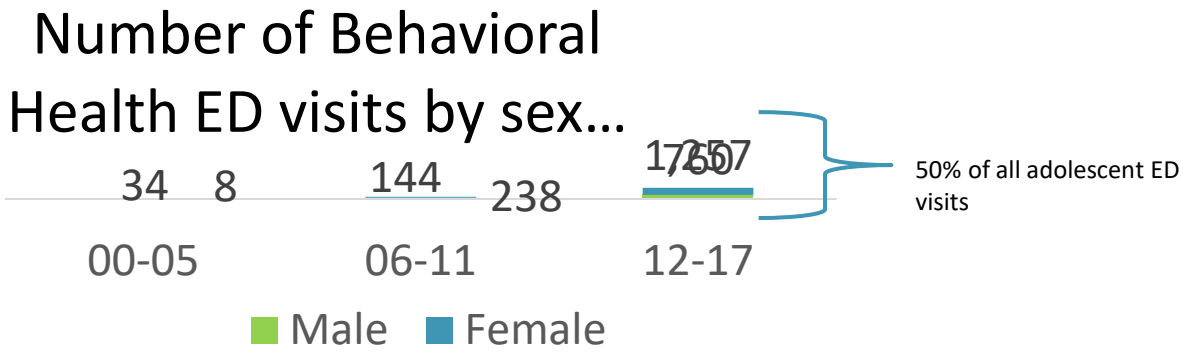
Outcomes

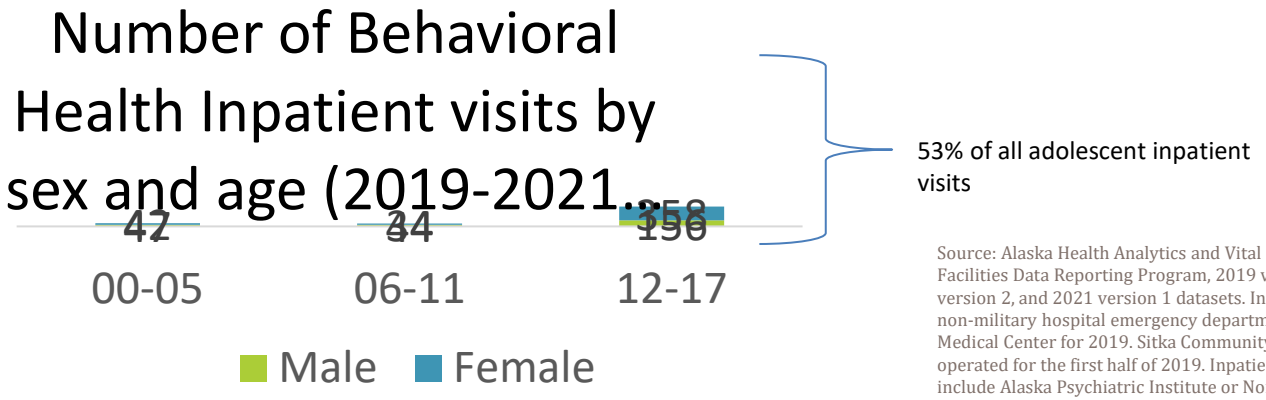
1. Developed a work plan with prioritized recommendations that will have a clear positive impact on child and adolescent behavioral health.
    a. Reduce psychiatric boarding of children and adolescents in Alaska's EDs and inpatient units.
    b. Identify internal process improvements and coordination among providers to standardize and improve care for behavioral health patients.
    c. Investigate alternative care settings and pathways to care for people presenting with an acute behavioral health need.
2. Stakeholders commit to implementing the work plan within their organization and being a champion of systems-level change.

Data from Alaska's Health Facilities Data Reporting Program

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

50% or more of all Behavioral Health ED and inpatient visits are by female adolescents ages 12 to 17. Younger patients tend to be male.



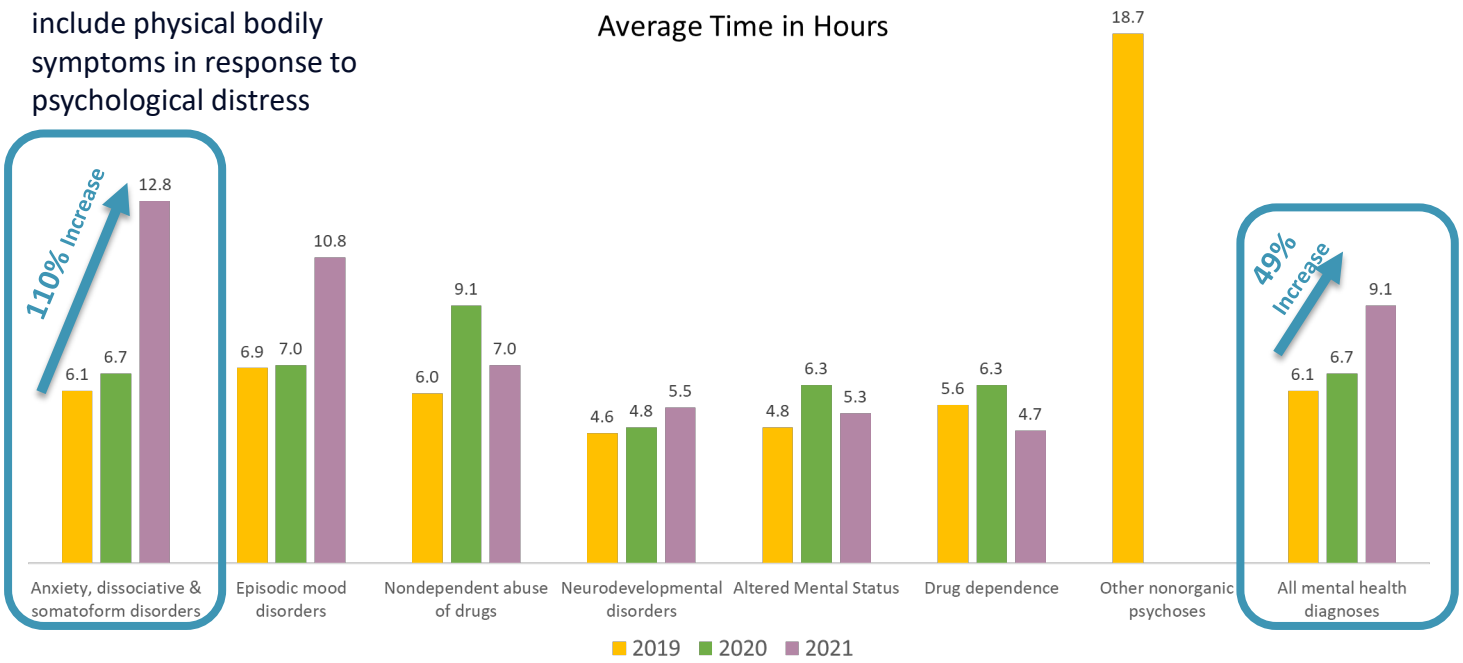


Source: Alaska Health Analytics and Vital Records, Health Facilities Data Reporting Program, 2019 version 5, 2020 version 2, and 2021 version 1 datasets. Includes all Alaskan non-military hospital emergency departments except Wrangell Medical Center for 2019. Sitka Community Hospital only operated for the first half of 2019. Inpatient counts do not include Alaska Psychiatric Institute or North Star Hospital.
* 2021 results are provisional

ASHNHA
ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

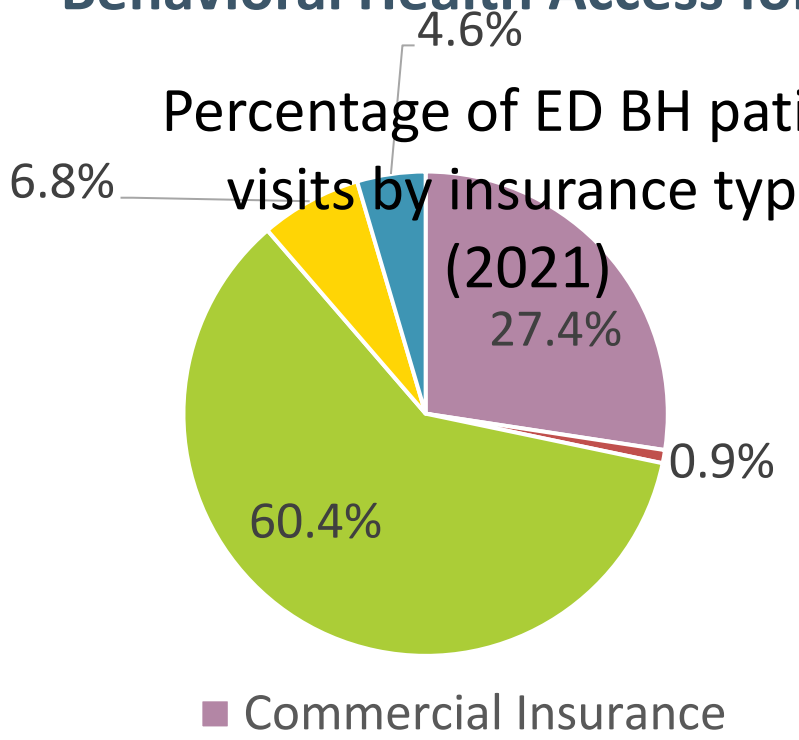
Time adolescents spent in Alaska EDs by year and Dx

Somatoform disorders include physical bodily symptoms in response to psychological distress



Source: Alaska Health Analytics and Vital Records, Health Facilities Data Reporting Program, 2019 version 5, 2020 version 2, and 2021 version 1 datasets.
Excluded facilities: Fairbanks Memorial Hospital, Yukon Kuskokwim Delta Regional Hospital, and Samuel Simmonds Memorial Hospital (Bristol Bay Area Health Center and Wrangell Medical Center are also excluded for only 2019) * 2021 results are provisional

Behavioral Health Access for Medicaid Enrollees



- 57% of Alaska children and youth are enrolled in Medicaid
- Access to behavioral health outpatient care severely limited for Medicaid enrollees
- 380 Alaska BH Providers listed in Psychology Today
  - 11 of these accept Medicaid
  - 3 of these had waitlists or were not accepting new clients

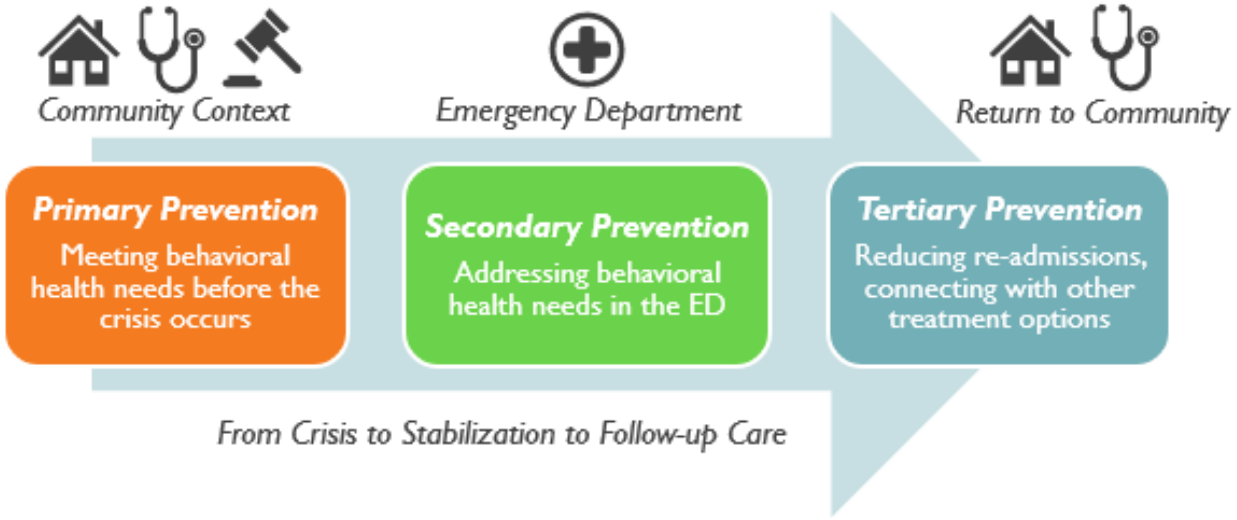


Continuum of Care

"We do not have a mental healthcare system. At best, we have a mental sick-care system, designed to respond to a crisis, but not developed with a vision of mental health that is focused on prevention and recovery"

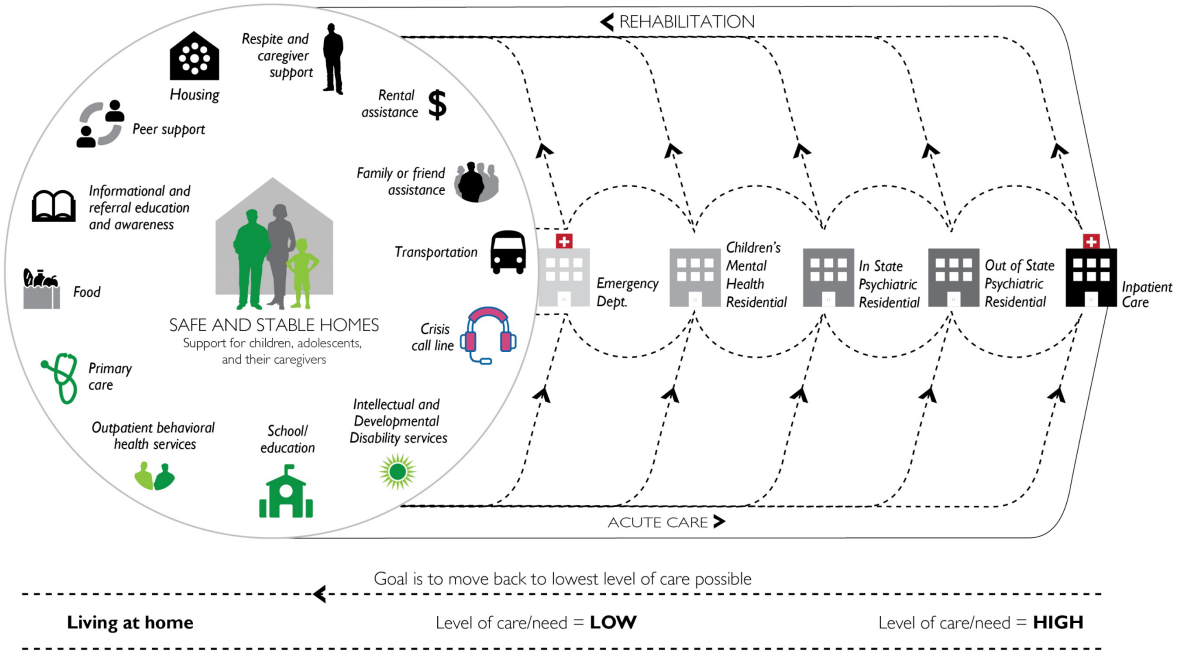
- *Thomas Insel, MD Psychiatrist and Neuroscientist from his book* Healing: Our Path from Mental Illness to Mental Health (2022)

Child and Adolescent Behavioral Health Continuum



Child and Adolescent Behavioral Health Continuum – Current State

Current state



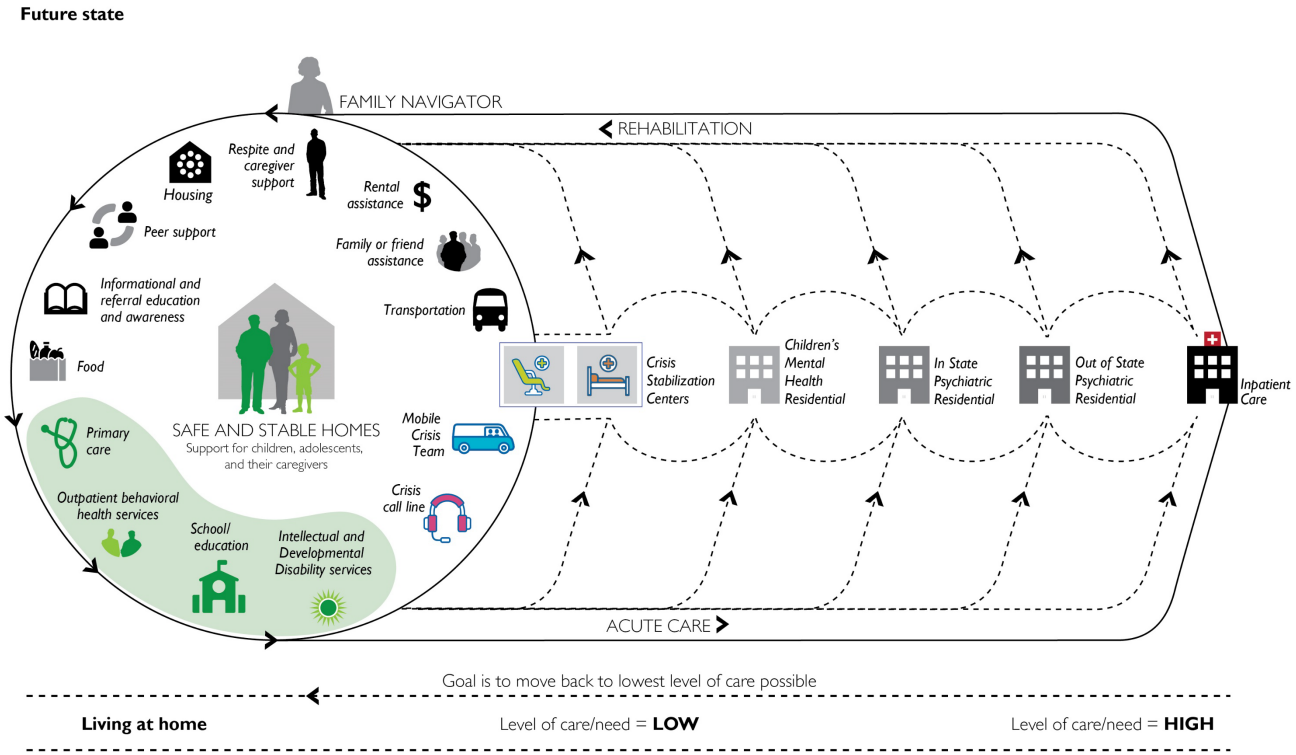
Service Gaps

- Care coordination
- Support for children and families in OCS/DJJ custody
- Transitional and navigation support
- Ready access to outpatient services
- Limited integration with school and primary care settings
- Robust crisis services outside of hospital settings
- Specialized residential settings
- Inpatient care

Challenges

- Payment parity, administrative burden and start-up costs for new services to develop full continuum.

Child and Adolescent Behavioral Health Continuum – Future State



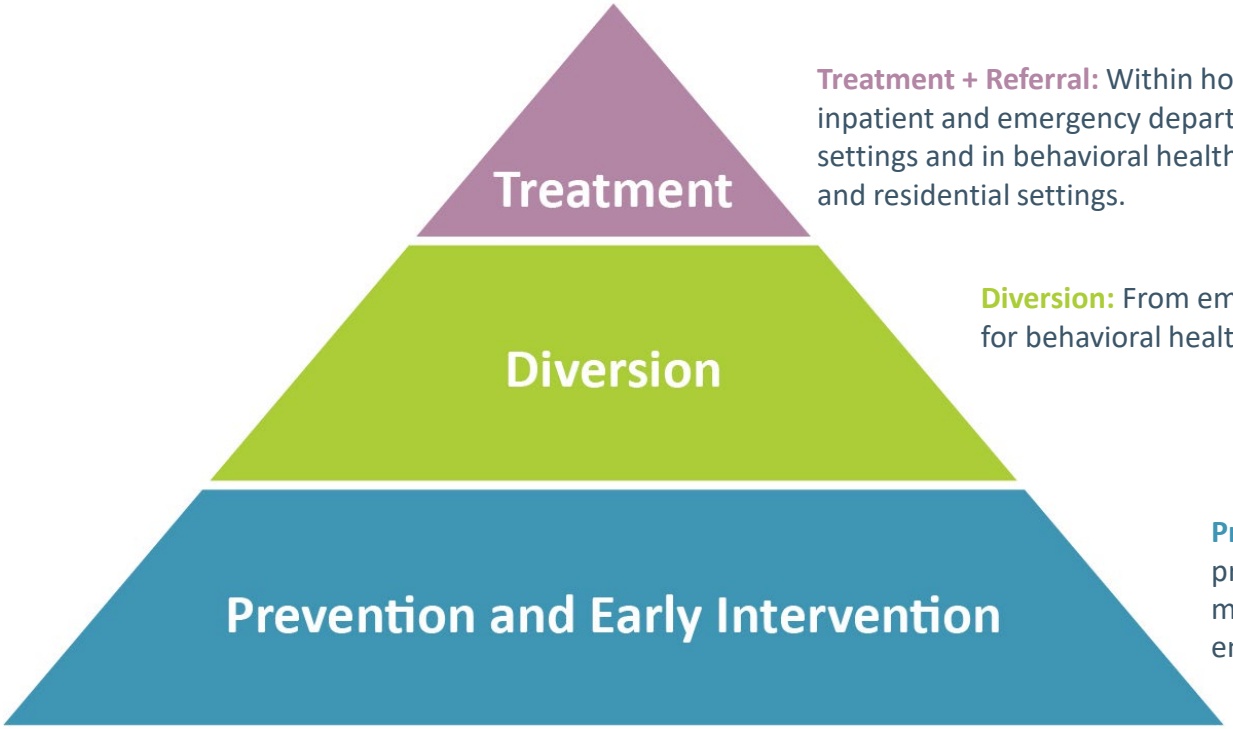
Three key areas for action:

1. Prevention, Early Intervention and Diversion
2. Behavioral Health Care in Emergency Department and Inpatient Settings
3. Treatment and Access Points for Discharge

Adolescent Behavioral Health Care in Alaska

Strategies & Recommendations

Levels of Systems Change



Treatment + Referral: Within hospital inpatient and emergency department settings and in behavioral health inpatient and residential settings.

Diversion: From emergency departments for behavioral health crisis care.

Prevention and early intervention: To prevent crisis, reduce the need for the most intensive levels of care, and increase engagement in services closest to home.

Prevention, Early Intervention and Diversion: *Findings from AHHA Workgroup Meetings, Provider Focus Groups and Interviews* (March – August 2022)

- Family basic needs are a huge driver: *"80% of families we serve are involved with OCS and probably half of them would not be if they had stable housing, food, and transportation."*
- We wait too long to intervene with hard-to-engage families: *"We might go 12 times before the parent lets you in, but we don't get paid for that."*
- No access to respite care for Therapeutic Treatment Homes to preserve placements.
- Outpatient and residential providers refer children and families to the emergency department seeking: 1) safety, 2) decompression, 3) a second opinion on level of care assessment, 4) help securing a referral.

How do we improve prevention, early intervention and diversion?

A. **Increase immediate access to outpatient care for Medicaid enrollees and universal access to school-based behavioral health services.**
B. Make behavioral health crisis care for children and youth widely available.
C. Support design and implementation of whole family programs and services, especially for those with OCS contact and those who are hard-to-engage.
D. Increase support for families to meet basic needs: housing, food, transportation.
E. Increase number of and support for foster and kinship families, including respite services.



How can we increase immediate access to outpatient care for Medicaid enrollees?

1. Create a clear pathway (and incentive structure) for behavioral health organizations to contract with independent providers to increase capacity for delivering Medicaid billable behavioral health services
2. Develop an accessible platform to connect all outpatient BH providers who accept Medicaid that identifies availability of assessment slots and appointments
3. Expand client eligibility for Medicaid School-Based Services (as allowed under the 2014 CMS free care rule reversal) to include all students
4. Expand Medicaid eligible provider types at FQHCs to include LPCs and LMFTs
5. Track CMS proposed changes to incentivize integration of psychologies and social workers into primary care settings by establishing billing codes.
6. Identify gaps in primary care provider knowledge and ability to connect patients to needed services

Treatment + Referral (BH Settings): Workgroup Meetings,

Provider Focus Groups and Interviews (March – August 2022)

- 1115 regulations not flexible enough to implement needed services in small communities, lack of capital funding; community-based services more costly to provide and rates don't align with those costs
- Rates don't support staff ratio for inpatient care for children under 11
- Administrative burden takes away from providing direct patient care and support AND increases dissatisfaction & burnout
- *"We had 'Bring the Kids Home'. We now need 'keep the kids out of hospitals ' and grant funding to support that."*



Treatment + Referral (ED + Inpatient): How do we improve the care provided in medical emergency departments and inpatient settings?

A. Implement health information exchange and a referral plan to allow patient record sharing between hospitals and behavioral health care settings.

B. Increase training for staff in child and adolescent development, trauma-responsive care, Zero Suicide, and advanced de-escalation techniques.

C. Increase access to family navigators and peer supports in hospital and emergency department settings.

D. Increase the number of behavioral health inpatient beds in locations around the state; allow billing for BH clinicians in hospitals.

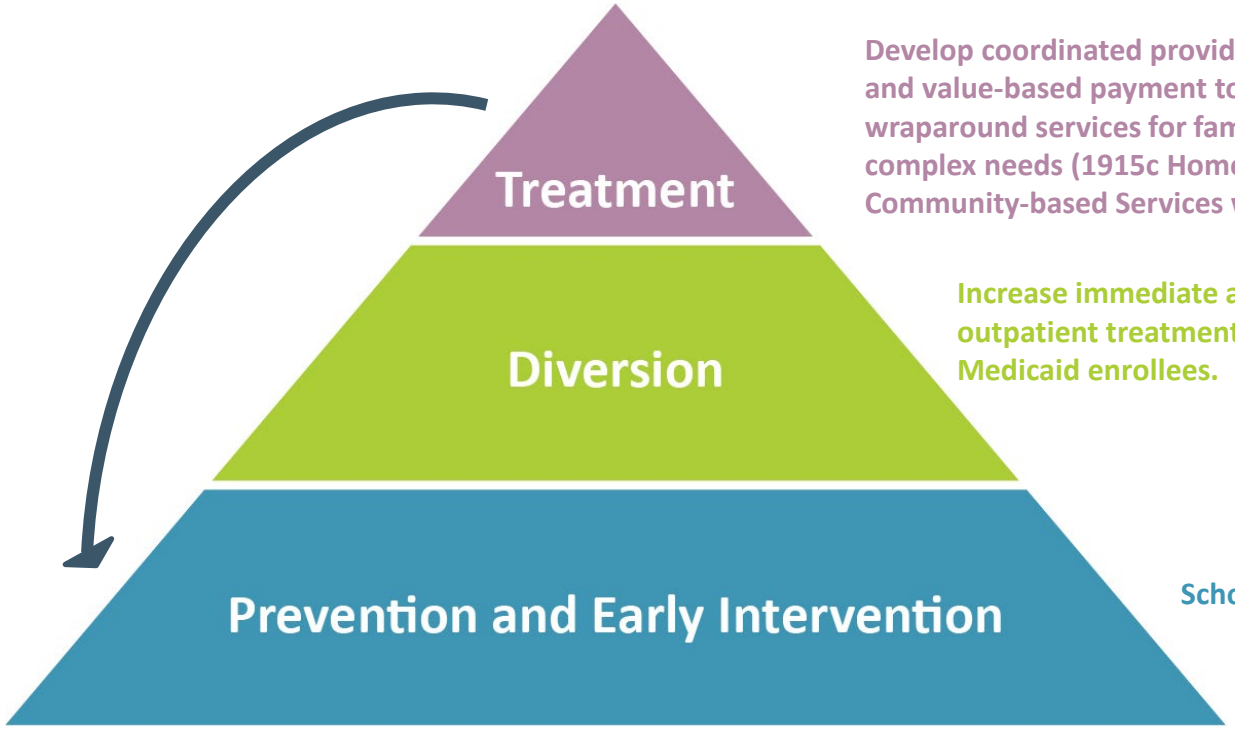
E. Support relationship development between hospitals and in-and out-of-state residential and inpatient treatment providers to streamline referral processes and create efficiencies.

F. Develop designated case conferencing support for children and adolescents held in EDs and inpatient units for longer than 24 hours and awaiting a discharge option.

How can we improve access to care and discharge placements?

A. **Increase the number of specialized residential facilities or group homes for younger children and children and youth with complex needs, in regions around the state; including locked Level 6 beds.**
B. **Increase targeted wraparound services and care coordination for children and families with complex care needs.**
C. Integrate connection to existing resources into hospital discharge flow and EHR (OpenBeds, Help Me Grow, PAL-PAK).
D. Increase family navigation and peer support services to support access to and transitions between levels of care.
E. Address systemic issues that impede service delivery (rates, administrative burden, workforce).

Levels of Systems Change

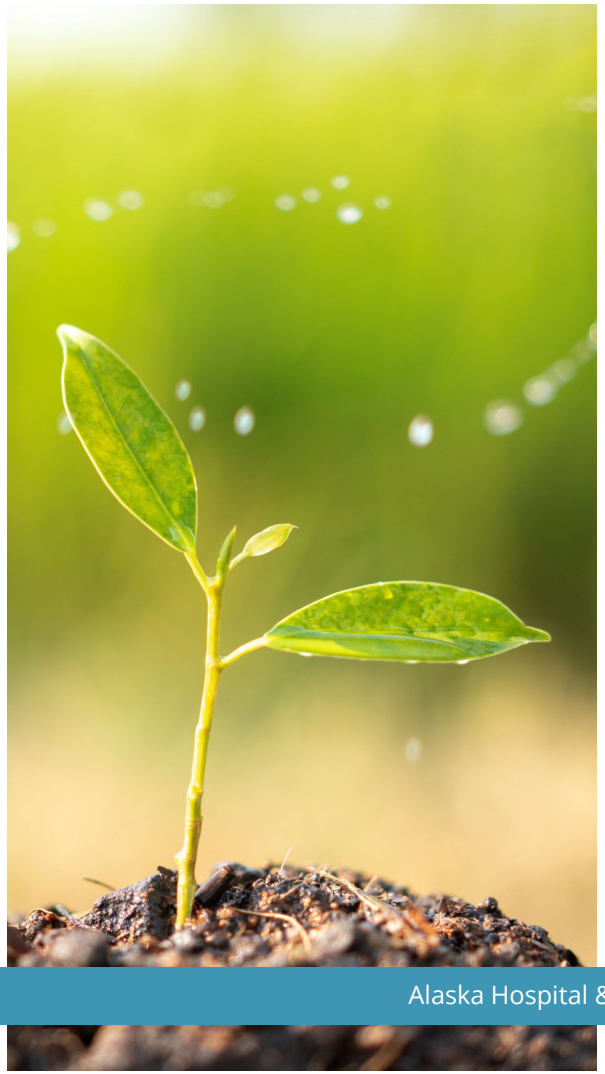


Develop coordinated provider networks and value-based payment to support wraparound services for families with complex needs (1915c Home and Community-based Services waiver).

Increase immediate access to outpatient treatment for Medicaid enrollees.

Implementation barriers include administrative burden and lower reimbursement rates for behavioral health services.

School-based services available for all.



Next Steps - Action Plan

Patients, advocates, family members, and providers all agree that the system of behavioral healthcare in Alaska is broken.

Simply doing more of what we've done in the past will not create the change we need to build a robust and sustainable system.

Building a robust and sustainable system

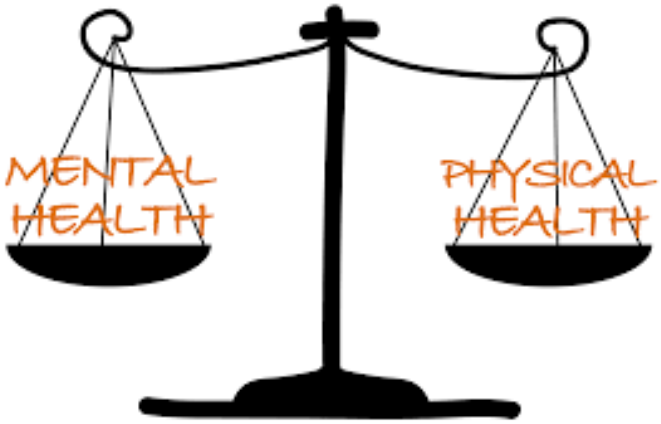
We need a system which:

1. **Promotes resilience and prevention**
2. **Supports universal mental health and wellness**
3. **Provides right level of care treatment for mental health conditions and substance use disorders locally**
4. **Provides support and treatment for complex and neuro-developmental challenges**

Building a robust and sustainable system



Foundational change



Priorities and values

Physical Health



Priorities and values

Physical Health



Dental Health



Priorities and values

Physical Health



Dental Health



Routine care

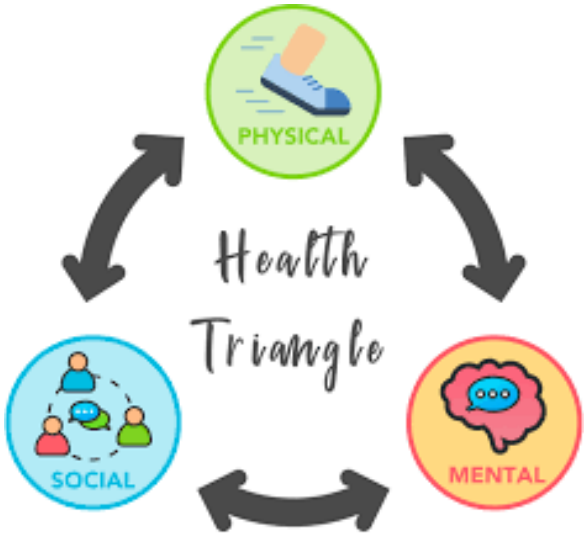


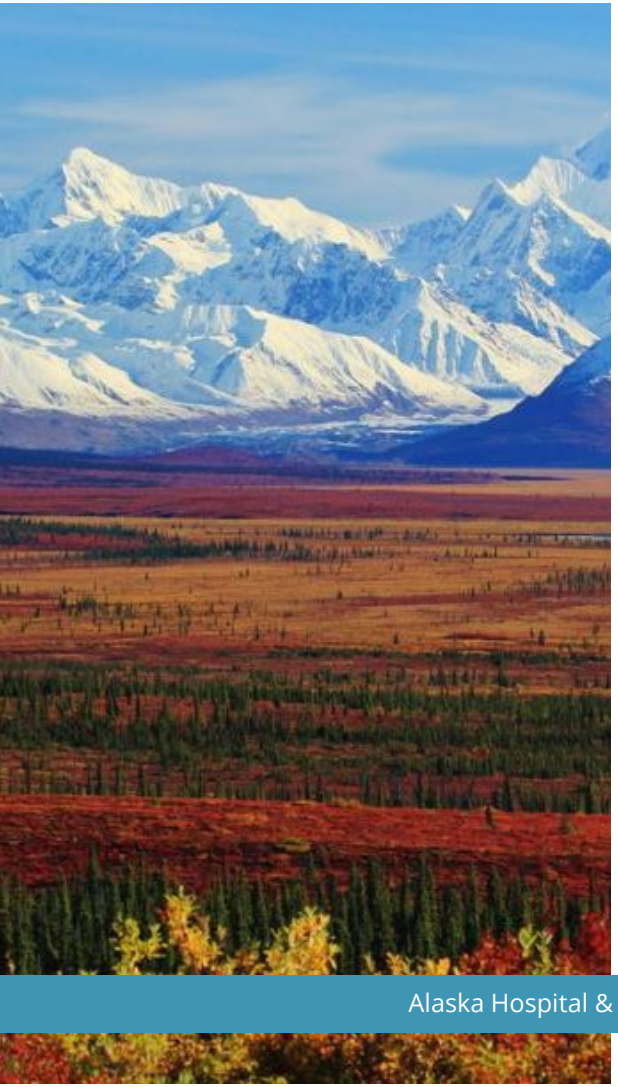
Seven focus areas that need to be addressed within this framework to realize the vision for a robust and sustainable behavioral health system.

1. Improving access and filling treatment gaps
2. Reducing administrative burden
3. Increasing reimbursement rates
4. Stabilizing & augmenting the workforce
5. Prioritizing prevention and early intervention
6. Establishing community wellness hubs
7. Expanding care coordination / case management



Achieving Health and Wellness





Thank you

Contact information:
Elizabeth King, MPH
eking@alaskahha.org

Adolescent report:
https://www.alaskahha.org/behavioral-health



alaskahha.org

Comagine Health

System of Care Considerations

Anne Zink, MD
Chief Medical Officer, Alaska Department of Health

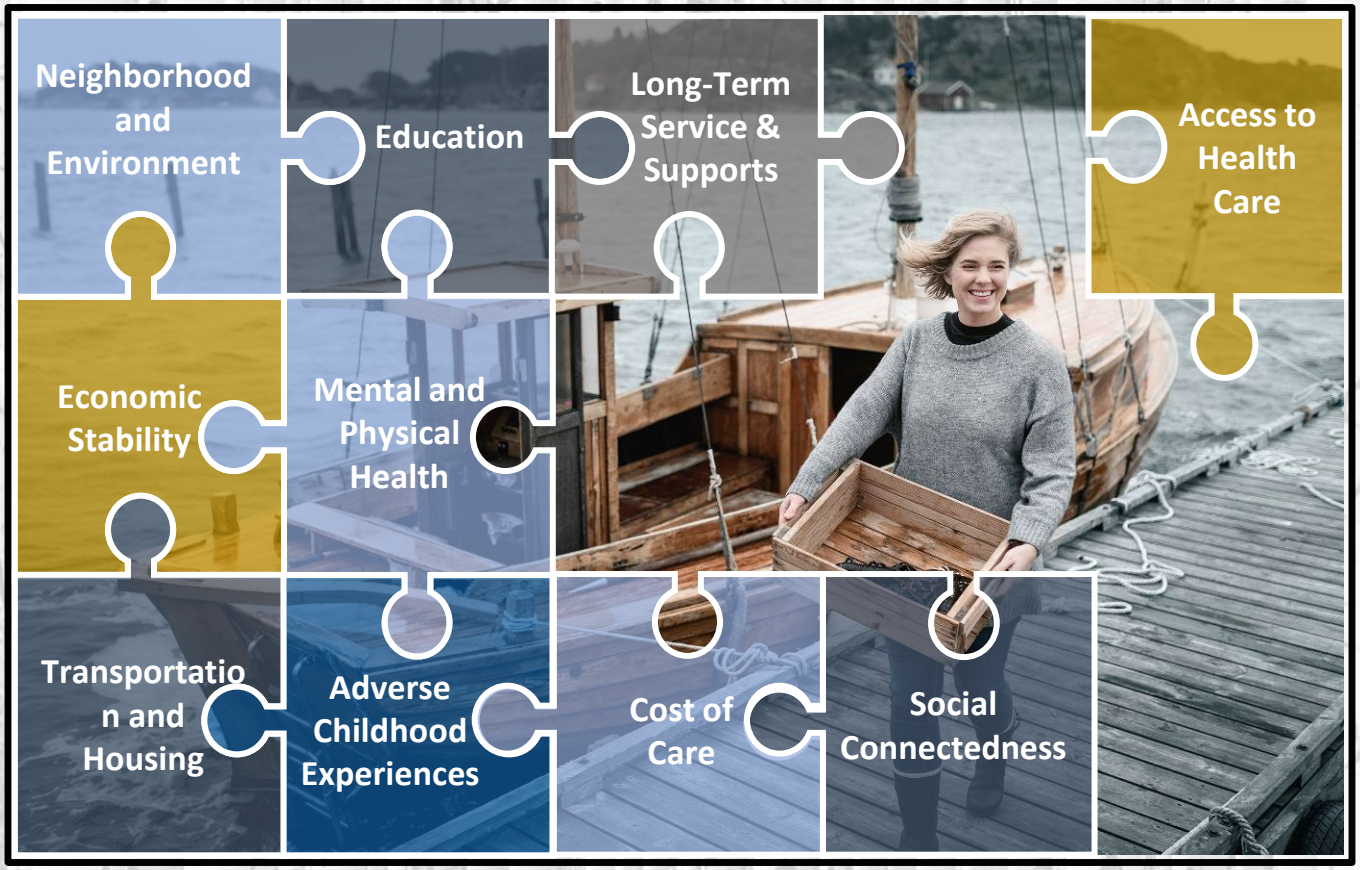
Improving Alaska's Systems of Care

Anne Zink, MD, FACEP
Chief Medical Officer, State of Alaska
Emergency Medicine Physician, Mat-Su

June 20, 2023 | Alaska Medicaid Behavioral Health Conference 2023

My Journey Into Public Health




Neighborhood and Environment
Education
Long-Term Service & Supports
Access to Health Care
Economic Stability
Mental and Physical Health
Transportation and Housing
Adverse Childhood Experiences
Cost of Care
Social Connectedness

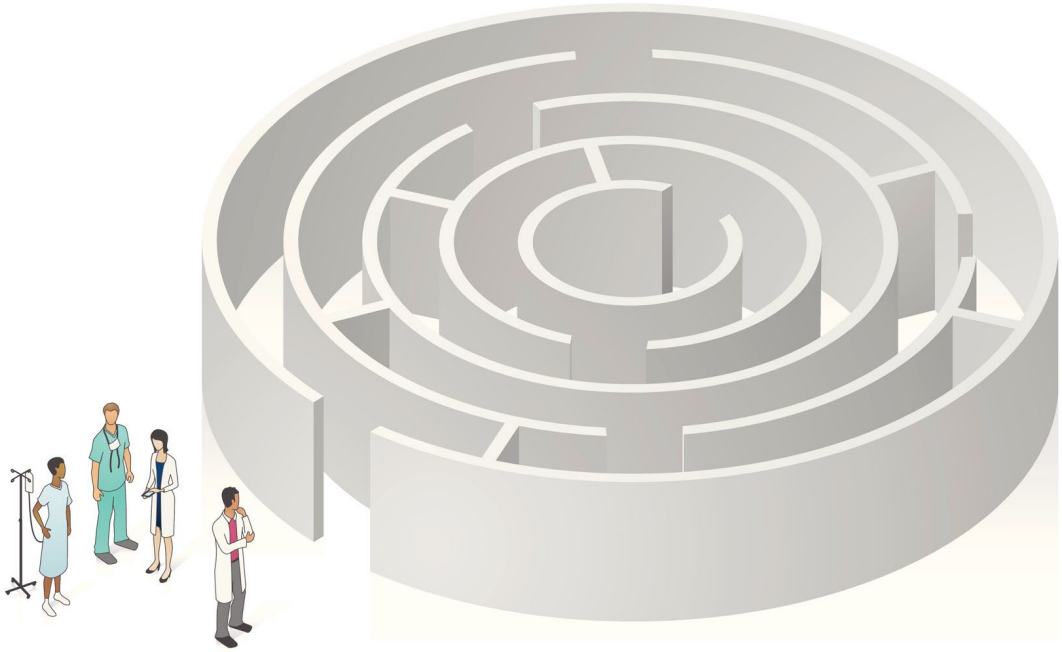
Hospital High Utilization and Behavioral Health

1,653 people

29,064 total emergency visits

Collective Utilization Category	Visit Count in 12 Months	Number of Patients	Total ED Visits	Median ED Visits	Total Inpatient Admissions	Median Inpatient Admissions	Average Length of Stay (Days)	Percent with a Behavioral Health Diagnosis	Percent that are Suspected Homeless	Percent with Care Insight
Rising Risk	10 - 14	984	11,260	11	1,059	0	3.9	66.7%	0.9%	8.1%
	15 - 19	322	5,371	17	406	1	3.5	78.0%	0.9%	7.1%
High Utilization	20 - 29	219	5,130	23	423	1	4.0	85.4%	0.9%	15.1%
	30 - 49	83	3,159	37	124	0	4.4	88.0%	0.0%	18.1%
Super Utilization	50 - 74	32	1,895	57	25	0	2.0	100.0%	0.0%	25.0%
	75 - 99	6	491	81	4	0	15.0	100.0%	0.0%	0.0%
Extreme Utilization	100 +	7	1,758	199	13	0	1.3	100.0%	0.0%	42.9%
Grand Total		1,653	29,064	13	2,054	0	3.9	73.3%	0.8%	9.8%

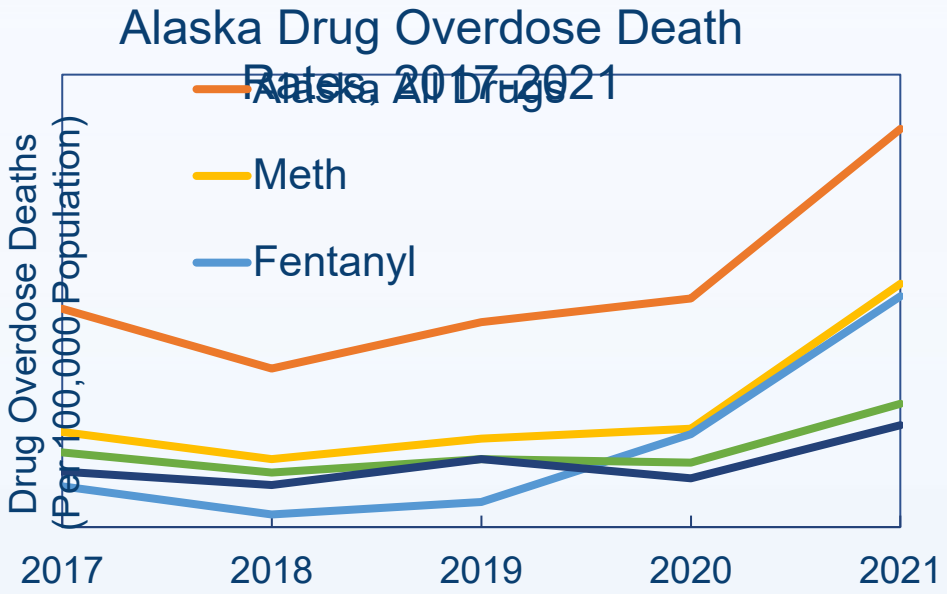
Making Systems Work for Patients







Overdose Deaths Continue to Rise

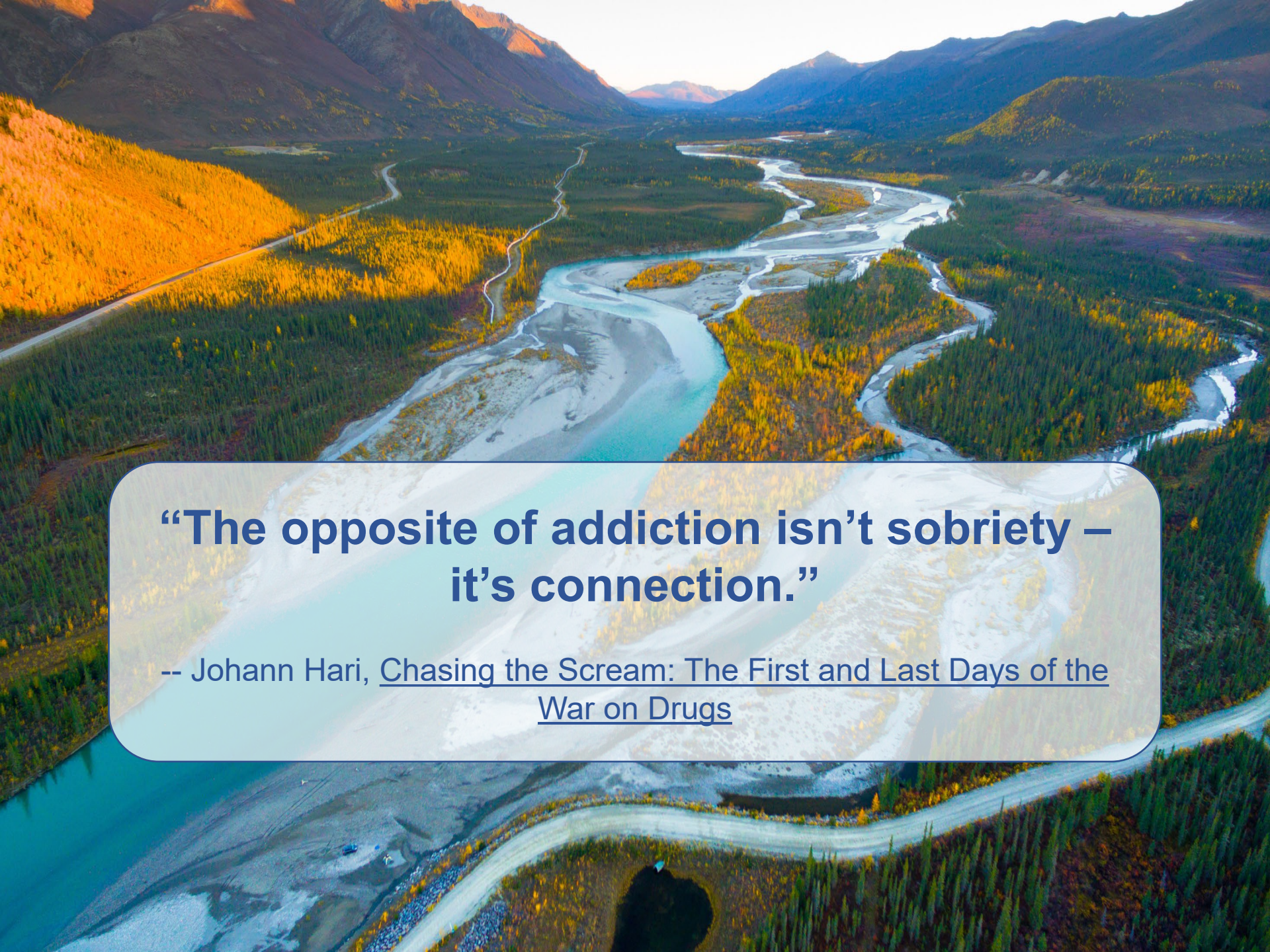


- Alaska's overdose death rate increased **74%** in 2021
- Over **70%** of opioid overdose deaths involve **fentanyl**

Source: Alaska Health Analytics and Vital Records (HAVRS) (2023).

I CARRY NARCAN
Reverse an overdose. Save a life.

STATE OF ALASKA DEPARTMENT OF HEALTH



“The opposite of addiction isn’t sobriety – it’s connection.”

-- Johann Hari, Chasing the Scream: The First and Last Days of the War on Drugs

History of Behavioral Health Systems in Alaska

1942 — Over 2000 Alaskans placed out of state

1961-62 — First in-state residential facilities open (Harborview and API)

1980s — Movement for deinstitutionalization

1994 — Alaska Mental Health Trust Authority re-established

2004-2014 — Bring the Kids Home

2016 — Medicaid Expansion

2019 — Behavioral Health 1115 Waiver

Today — 64 children placed out of state

Success Story: Bring the Kids Home (2004-2014)

- Significant reductions in the number of out-of-state placements from 749 in 2004 to 90 in 2011.
- Out-of-state placements continued to remain below 100 through the termination of the BTKH initiative in 2014 and numbered 64 as of last week



Supporting Alaskans Close to Home

1) Since December 2020, Alaska has reduced the number of children on Medicaid receiving care out of state by 25%.

2) Out of state care is an option of last resort.

3) Children placed out of state are closely monitored by dedicated staff to coordinate care and ensure facility compliance.

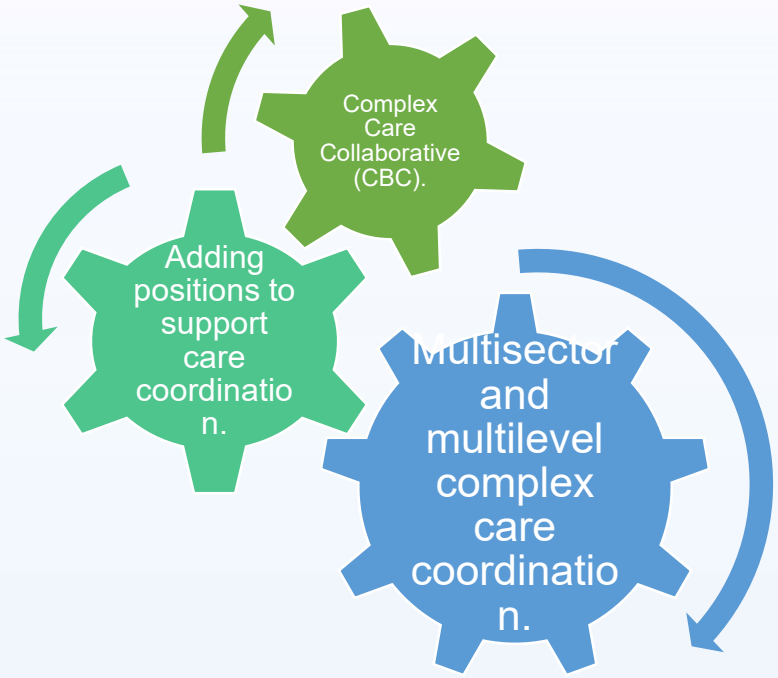


Charting a path forward



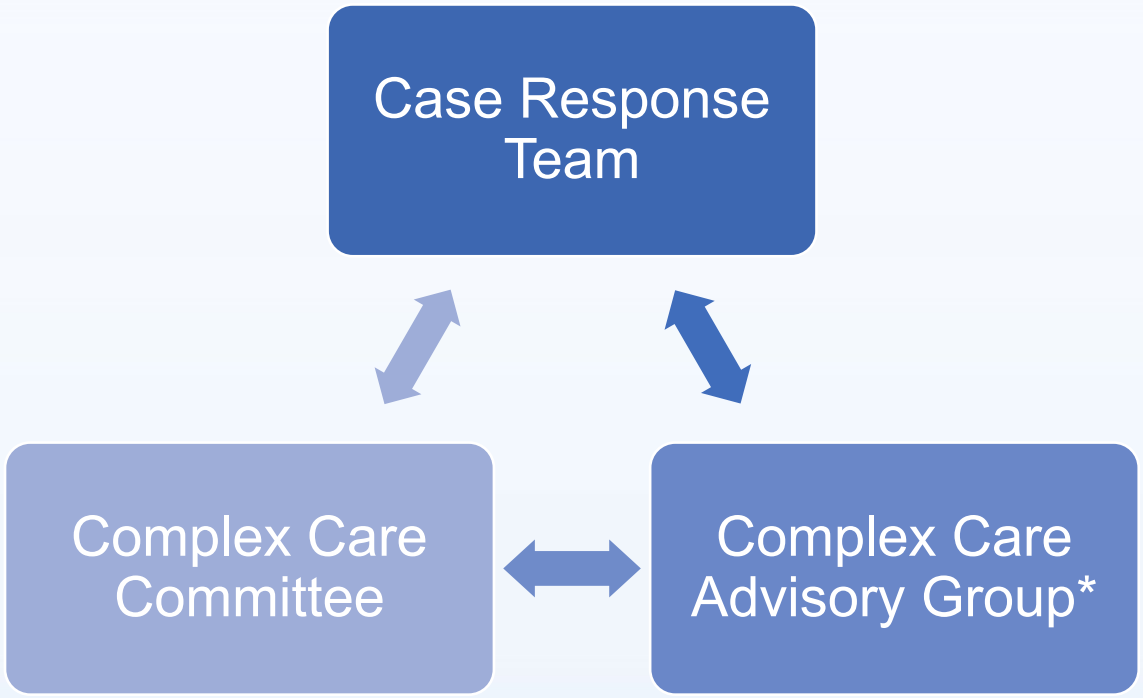
Complex Care Initiatives

Following DHSS split, DOH and DFCS are establishing *new structures* to ensure seamless complex care coordination across departments

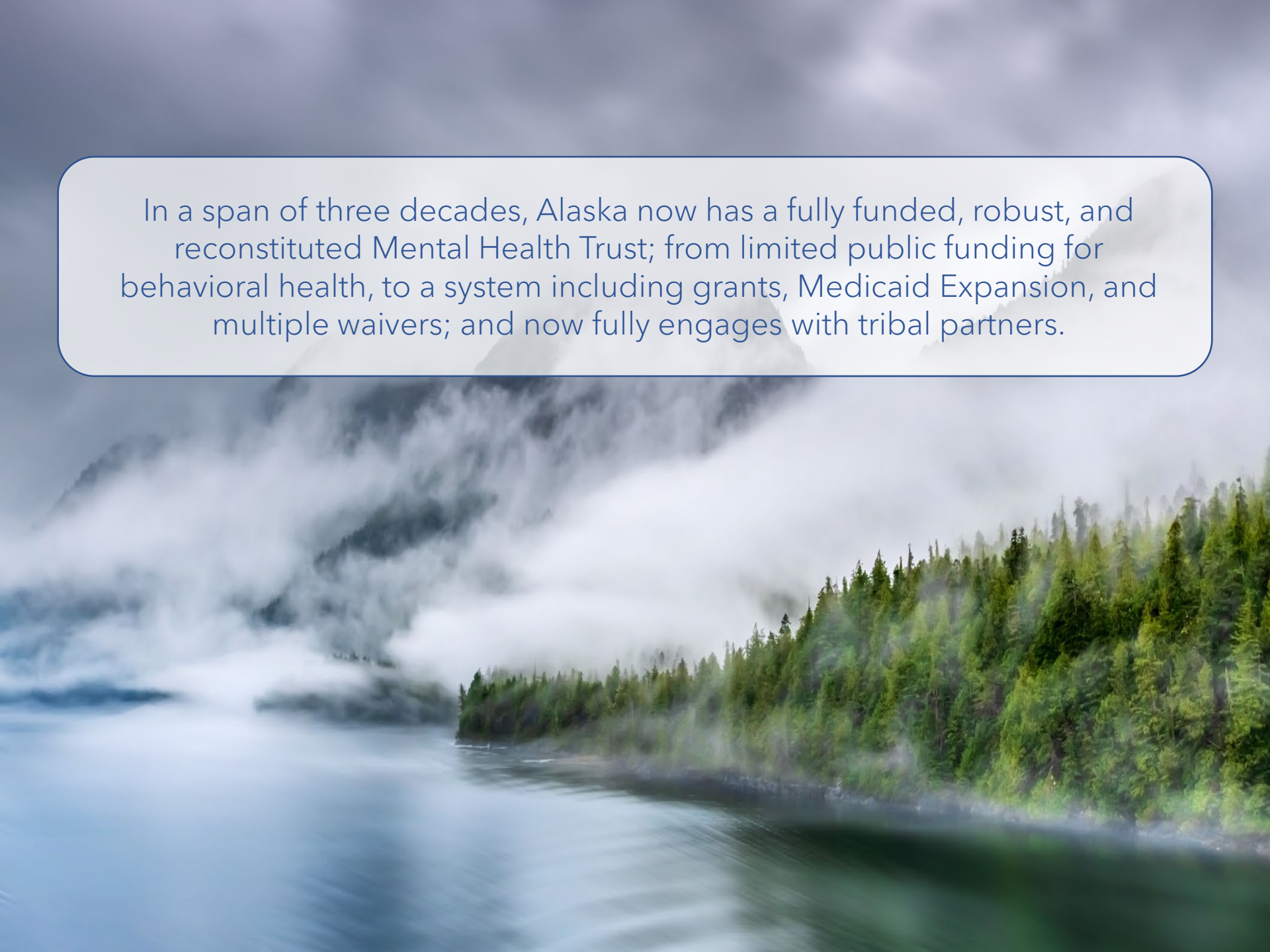


AK | DFCS
ALASKA DEPARTMENT OF FAMILY AND COMMUNITY SERVICES

Complex Care Coordination

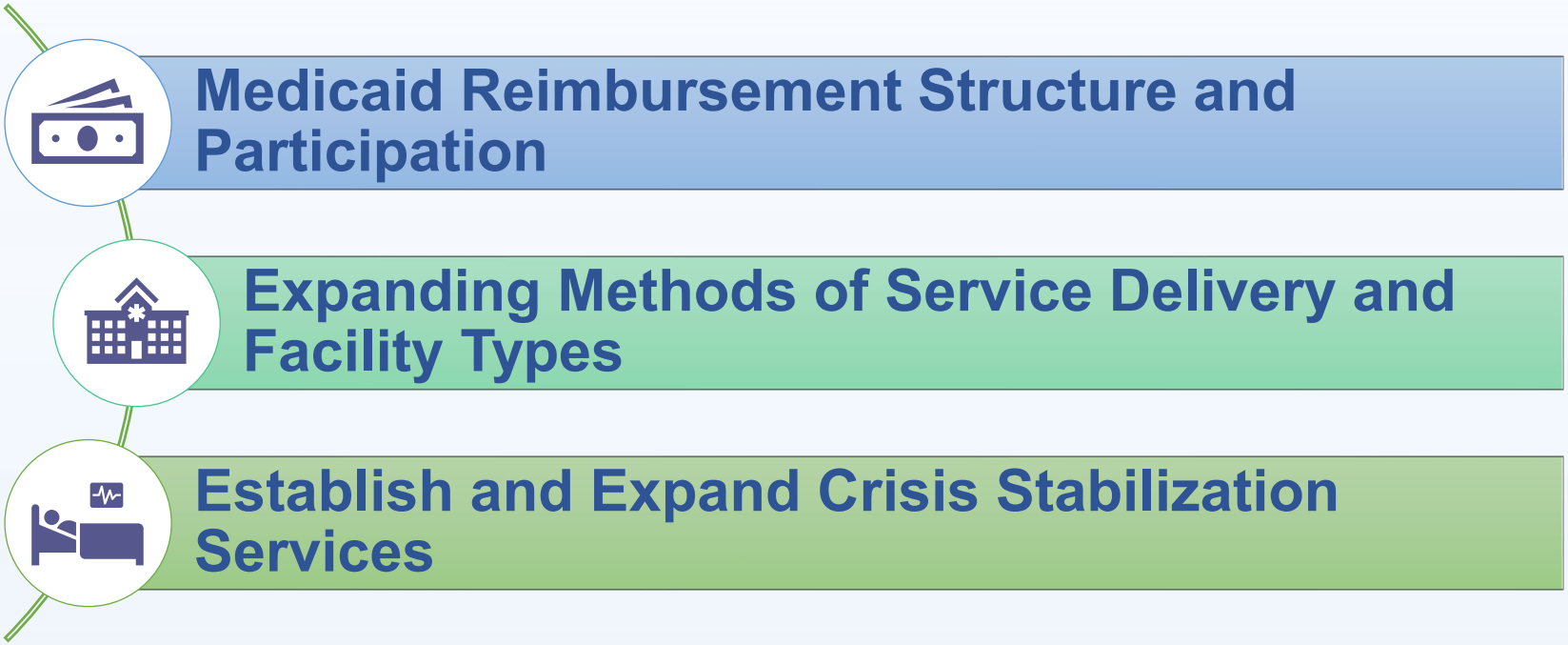


AK | DFCS
ALASKA DEPARTMENT OF FAMILY AND COMMUNITY SERVICES



In a span of three decades, Alaska now has a fully funded, robust, and reconstituted Mental Health Trust; from limited public funding for behavioral health, to a system including grants, Medicaid Expansion, and multiple waivers; and now fully engages with tribal partners.

Three Key Focus Areas Moving Forward



Medicaid Reimbursement

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



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 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 for waiver renewal February 27, 2023.

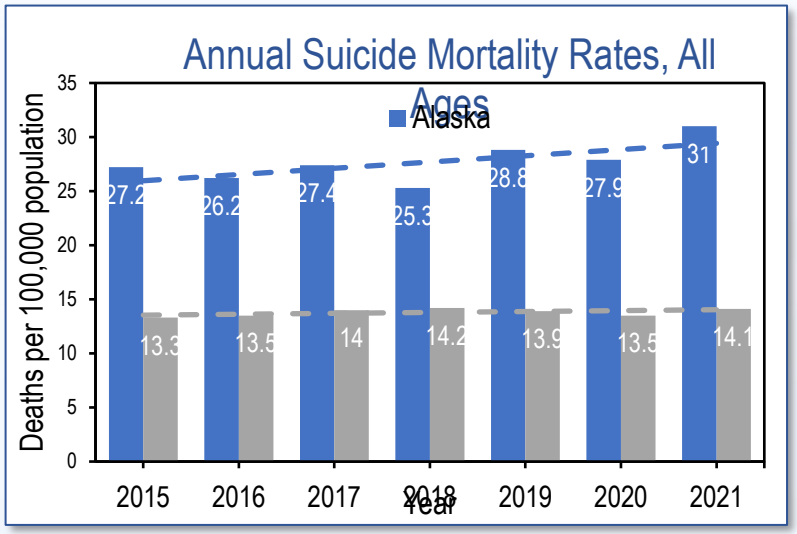
Home and Community Based Services Waivers

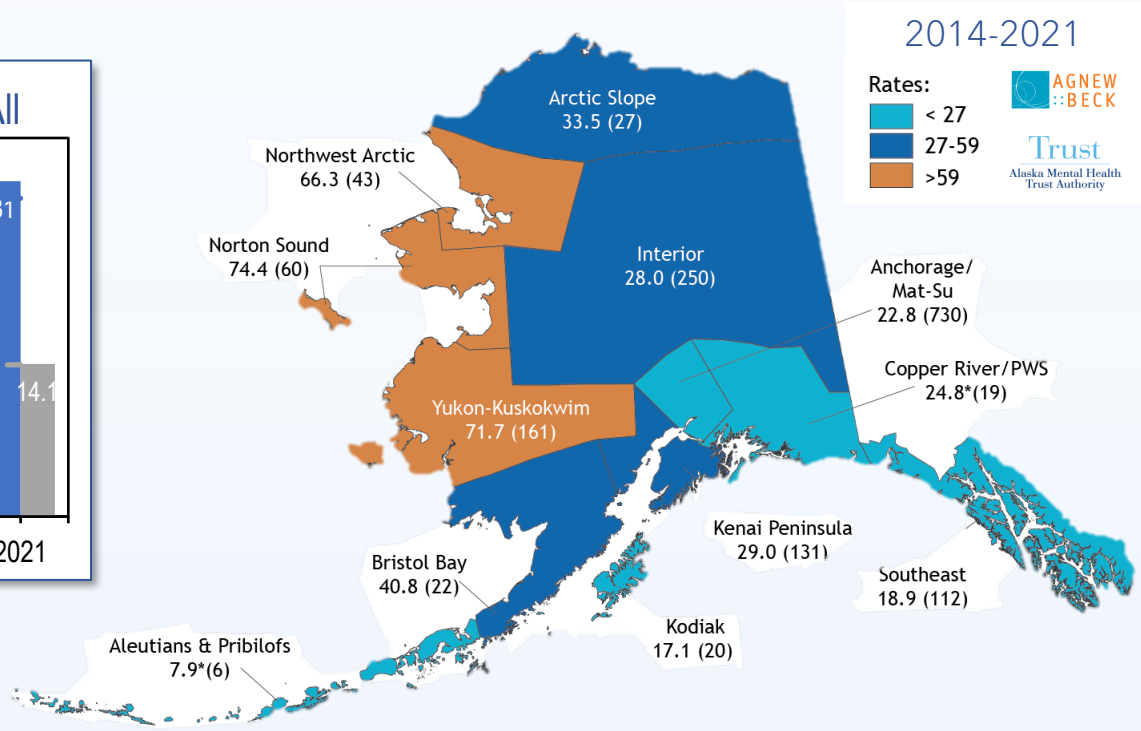
1915(c) waivers help people remain in their home or community when their needs would otherwise require an institutional level of care.

Alaska has five 1915(c) waivers:

- Individuals with Intellectual and Developmental Disabilities (IDD)
- Alaskans Living Independently (ALI)
- Children with Complex Medical Conditions (CCMC)
- Individualized Supports Waiver (ISW)
- Adults with Physical Developmental Disabilities (APDD)

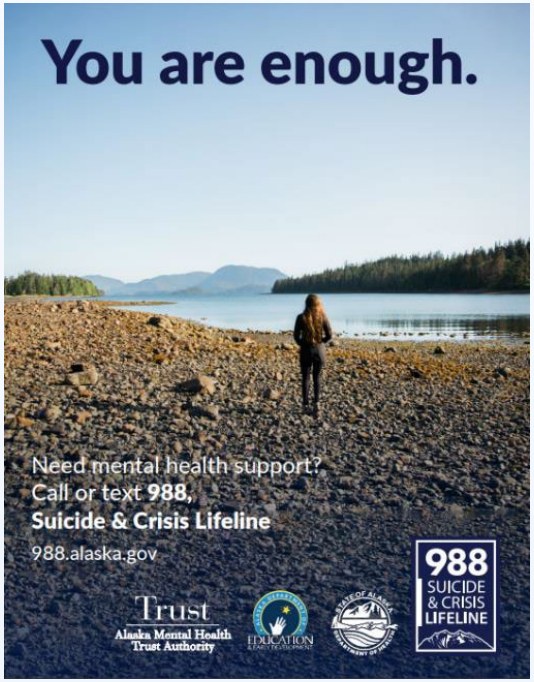
Suicide Deaths in Alaska





Sources: Alaska Health Analytics and Vital Records (2023), CDC National Center for Health Statistics/WONDER (2023).

Suicide Prevention



- **988** is here for all Alaskans (call or text 988 or chat 988lifeline.org)
- **9 out of 10 people** who survive a suicide attempt do not go on to die by suicide later
- **Zero Suicide Initiative**
- **Youth** and young adult suicide prevention **media campaigns**
- **Out of Darkness** community walk

988 SUICIDE & CRISIS LIFELINE

988.alaska.gov

STATE OF ALASKA DEPARTMENT OF HEALTH

Healthy Alaskans 2030

- Alaska's Health Improvement Plan
- Unique state-tribal partnership
- Outlines health priorities for each decade with specific:
  - evidence-based strategies
  - shared metrics
  - key community partners
- Collective impact model engages the community at many levels



ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

HealthyAlaskans.org

STATE OF ALASKA DEPARTMENT OF HEALTH

Healthy Alaskans 2030



To meet our Healthy Alaskans 2030 goals, we will need actions at both the





Target Met: 1

Improving: 10

Not Improving: 18

HealthyAlaskans.org

STATE OF ALASKA DEPARTMENT OF HEALTH

Engaging Across the Spectrum



Engaging in Community



Thank You

Qaĝaasakung
Aleut

Quyanaa
Alutiiq

Quyanaq
Inupiaq

AwA'ahdah
Eyak

Mahsi'
Gwich'in Athabascan

Igamsiqanaghalek
Siberian Yupik

Háw'aa
Haida

Quyana
Yup'ik

T'oyaxsm
Tsimshian

Gunalchéesh
Tlingit

Tsin'aen
Ahtna Athabascan

Chin'an
Dena'ina Athabascan


Questions?

Comagine Health

Break

Back in 15 minutes

Comagine Health

Ethics, Records and Utilization Review

Linda Rasmussen, LCSW

Lead Clinical Reviewer, Comagine Health

Presentation Goals

- Learn about ethical and legal issues surrounding submitting clinical documentation in utilization reviews
- Provide utilization review processes and updates for Alaska Medicaid psychiatric programs
- Review evidenced-based guidelines in submitting utilization reviews
- Discuss diagnosis and ethical dilemmas in payment limitations
- Demonstrate collaboration with the State of Alaska and providers in the ethical submission of the utilization review process

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Considerations in Submitting Clinical Documentation

- Clinical reviews are a legal document with legal ramifications
- By submitting a clinical review, the submitter is attesting to the following:
  - Affirming the assessment of the recipient's symptomatology, current level of functionality is documented in the recipient's clinical record
  - The treatment plan services, units and duration requested are medically necessary and consistent with the recipient's level of impairment

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Ethical and Legal Considerations in Submitting Clinical Documentation (cont.)

- The clinical records include everything that is being submitted.
- The clinical records are available for inspection upon request.
- Approvals are subject to all Medicaid/Denali KidCare program rules and regulations.
- Department of Health & Social Services may recoup payment for any services that are not properly documented, or not in compliance with program rules.

Ethical and Legal Considerations in Submitting Clinical Documentation (cont.)

- The State of Alaska DBH employees have full access to everything submitted to Comagine Health by the providers.
- When doing on-site reviews, the State of Alaska DBH employees compare what is entered into the Comagine Health reviews to what is documented in the charts.
- There are federal regulations, as well as state regulations, with specific requirements that need to be met and documented in the recipient's clinical charts.

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Ethical and Legal Considerations

- Primary diagnosis and payment limitations
- Clinical documentation submitted
- Document all pertinent information
- Timeframes of documentation
- Discharge planning

Alaska Division of Behavioral Health Utilization Reviews

- Inpatient acute and residential psychiatric review types:
  - Admission review
  - Master Plan of Care review
  - Continued stay review
  - Retrospective review
  - Peer review
  - Appeals

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Tools to Support Your Review

http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-resources

- Provider manuals
  - Inpatient Psychiatric Review
  - Community-Based Youth Residential Behavioral Health Services Review
- Provider training
- Late Submission/Retro Review Request form
- Comagine Health Provider Portal User Guide and training videos
- Contact information for Comagine Health
- Map of Alaska regions
- List of in-state providers by region and contact information
- Link to Alaska Division of Behavioral Health website
- Incident Report forms and instructions

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Provider Responsibilities

- Review submission and timelines
- Discharge planning
- Report discharges
- Travel authorization
- Incident reports

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Review Submission

Providers are required to:

- Submit timely reviews via the Comagine Health Provider Portal (CHPP)
- Submit reviews for recipients who are also covered by other Third Party Liability (TPL) resources
- Furnish complete, accurate demographic and other information
- Give comprehensive answers on the appropriate review questionnaire

Comagine Health

Prior Authorization Submission Timelines

- Acute care admissions
  - 2 days prior to admission if travel is involved
  - Same day if no travel is involved
- PRTF admissions
  - 7 days prior to admission if travel is involved
  - 3 days prior to admission if no travel is involved

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Continued Stay Review Submission Timelines

- PRTF care
  - 3 days prior to “Next Review Date”
- Acute care
  - 2 days prior to “Next Review Date”

Comagine Health

Pended Review Timeline

1. Comagine Health notifies provider via the Comagine Health Provider Portal
2. Provider has 7 calendar days to submit the requested information
3. Possible technical denial after 7 calendar days

Comagine Health

Acute and PRTF Travel Authorization

- Provider expecting to admit client is responsible for timely submission of the prior authorization review
- When certification (approval) is given, use the Prior Authorization number assigned to the case for travel for admissions
- Conduent State Healthcare is the authorized agency for travel
  - Toll-free in Alaska (800) 770-5650
  - Outside of Alaska (907) 644-6800

Comagine Health

Diagnosis Requirements

Must have valid ICD-10 code with all digits for payment.

For example:

- F43.10 Post-traumatic stress disorder, unspecified
- F33.1 Major depressive disorder, recurrent, moderate
- F84.0 Autistic disorder

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Admission Review

- All demographic questions must answered in full and correctly on the Admission Review questionnaire
- All questions must be answered comprehensively and correctly
- Acuity must be provided with dates and description of events based on requirements for the proper level of care
- Put current information under the Acuity section
- Put historical information under the Psychosocial section

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Admission Review (cont.)

- Mental Status Exam is required for all admission reviews
  - Mental Status Exam *date* and who it was performed by must be provided in the Admission Review questionnaire
  - Issues must be recorded in the free text under question #48 (description of the acute disturbances supporting the need for admission)

Comagine Health

Required Documentation for Admission

Submit all clinical documentation that supports the need for this level of care. Documentation must include:

- Dates
- Seriousness
- Frequency of symptoms
- Current acuity (If this is chronic, why now?)
- What happened while in acute care that didn't stabilize enough for a lower level of care?

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Details to Use in Reviews

Per DBH:

Use These	Not These
Crying at least 3 times daily, Tantrums that include screaming, crying, yelling, and biting arms, Excessive clinging	Cries frequently, Angry outbursts
Hypervigilance, Excessive fear (describe)	Nervous, Afraid
Jumped into open part of frozen lake…, Fire setting in last week	Risky behaviors, Hx setting fires
Runaway less than 24 hours (48 hrs, X # days)	Runs
Self-injurious behavior by cutting arms leaving scars, Hallucinations in last week (specifically describe)	Hurts themselves, sees things

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Details to Use in Reviews (cont.)

Use These	Not These
Drop in school grades (A to D in 6 Weeks)	Not doing well in school
Suicidal/homicidal ideation with/without plan, Self harm that includes third degree burn	Wants to hurt self
Detention @ least 2x in last 5 days, suspended	Made to stay after school
Impulsive, property destruction (describe)	Acts without thinking
Absent 5 days from work in last month	Misses work
Arrest/illegal activity in last month	Legal troubles
Socially withdrawn in last month	Stays to themselves, loner

Details to Use in Reviews (cont.)

Use These	Not These
In the last month	Has a history of
3x week for last 6 months	Recently
In the last 48 hours	Frequently, Often
In the last month	Seldom

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Requirements to Support Admission Acuity: Acute Care

48. Describe acute disturbances related to the behavioral disorder:
    - Symptoms within the last 24 to 48 hours
    - Dates, seriousness and frequency of symptoms
    - Specific description of symptoms

Requirements to Support Admission Acuity: PRTF

48. Describe acute disturbances related to the behavioral disorder:
    - Symptoms within the last 60 days with emphasis on last 30 days
    - Symptoms while in acute care
    - Specific description of symptoms
    - Lower level of care
    - History of symptoms over 6 months

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Example of Documentation for Admission Acuity: Acute Care

Describe acute disturbances related to the behavioral disorder:

Patient is admitted today with homicidal and suicidal ideation.

Comagine Health

Example of Documentation for Admission Acuity: Acute Care

Describe acute disturbances related to the behavioral disorder:

Patient is admitted today after threatening to kill teachers and classmates and then self with his father's 22 pistol. Patient has access to guns and bullets. He became angry and was swearing at teachers and punched a hole in the wall, threw over desk and scattered papers all over the room.

Admission Review Acuity: PRTF

57. Describe acute disturbances related to the behavioral disorder:

Patient is admitted due to a history of suicidal threats, homicidal threats, aggression and oppositional/defiant/impulsive behaviors.

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Admission Review Acuity: PRTF

57. Describe acute disturbances related to the behavioral disorder:

    Patient admitted to acute care on March 12, 2020, after threatening to kill teachers and classmates and then self with his father's 22 pistol. Patient has access to guns and bullets in his home. He was swearing at teachers and punched a hole in the wall, threw over desk and scattered papers all over the room. He has been in acute care 4 times in the last year. While in acute care he….

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Plan of Care (POC) Review

- PRTF level of care
- Acute level of care
- Required elements to be addressed in the POC

Comagine Health

Plan of Care

The Plan of Care (POC) is required to:

- Include a discharge plan prepared *at the time of admission*
- Specify the approximate date for discharge
- Be formulated in consultation with the recipient and the recipient's parents, legal guardian or other individual to whose care or custody the recipient will be released following discharge

Plan of Care (cont.)

POC reviews are required to include updated discharge planning information that provides increasingly more detailed information regarding:

- The recipient's anticipated post-discharge service needs
- The recipient's prospective service providers
- Other provisions necessary for the transition to a less restrictive environment

Comagine Health

Plan of Care (cont.)

- The Master Plan of Care (MPOC) should cover everything that is to be completed *throughout the entire expected length of stay*.
- The POC must include goals and objectives related to family therapy, group therapy and individual therapy that are connected to problem statement.
- If the recipient is in OCS or JJ custody, the POC must include goals and objectives related to contact with case worker.

Plan of Care (cont.)

Clearly document the *measurable* goals and objectives:

- Problem statement related to each diagnosis
- Goals and objectives related to problem statement
- Modalities in which goals and objectives will be addressed
- Update progress on goals and objectives in every review for each problem statement and for every type of therapeutic setting (individual, family and group psychotherapy)

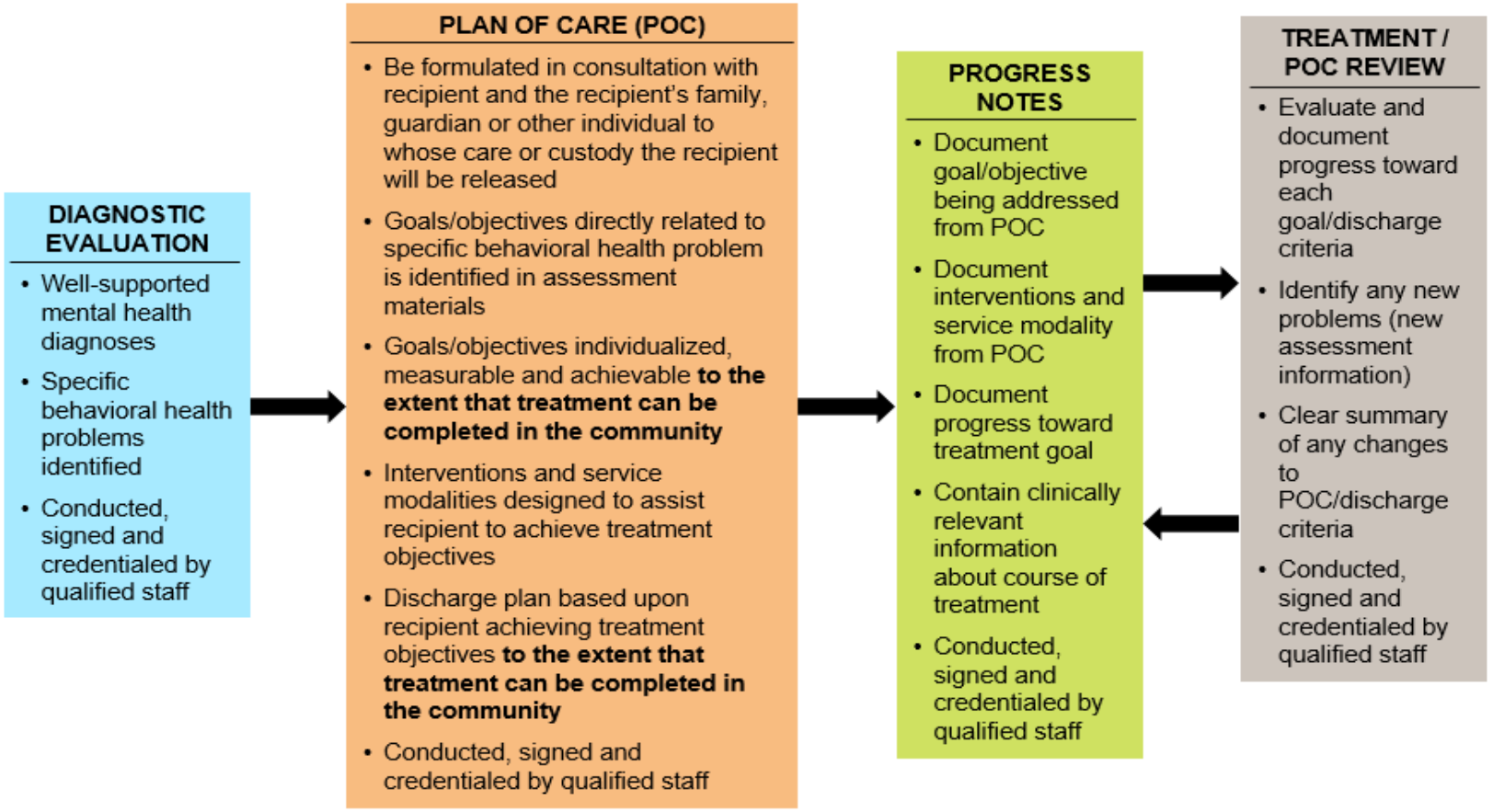
Treatment Plan Goals and Objectives

Examples, per DBH:

Global Goal/Objective	Example Measurable Goal/Objective
Eliminate assaultive behavior	Eliminate episodes of hitting and slapping peers at school
Reduce verbal aggression	Reduce occurrences of saying, “I’ll kill you,” and, “I’ll beat you up,” to siblings and classmates by 80%

Medical Necessity Practice and Documentation

All services must be rendered in compliance with Medicaid Program rules, regulations and statutes.



Required Documentation for Continued Stay

Submit all clinical documentation that supports the continued need for the requested level of care. Documentation must include:

- Clear description
- Seriousness
- Frequency of symptoms and behaviors
- Current acuity (*this review period*)

Comagine Health

Required Documentation for Continued Stay (cont.)

- Updates on:
  - Diagnostic evaluation
  - Medication changes and effectiveness
  - Current behavioral impairments
  - Measurable treatment goals/objectives and progress made on the goals/objectives
  - Goals and objectives in each modality (individual, family and group psychotherapy)

Example of Documentation for Continued Stay Review Acuity

Describe acute disturbances, self care deficits or imminent risk to self or others or impaired safety or severely impaired role functioning:

Despite depression and SI, patient appears to participate in program and is participating well.

Comagine Health

Example of Documentation for Continued Stay Review Acuity

Describe acute disturbances, self care deficits or imminent risk to self or others or impaired safety or severely impaired role functioning:

Patient struggles with depression on a daily basis as evidenced by her frequent statements of wishing she would die, telling peers when she leaves this facility she will hang herself, and her disclosures to her therapist that she thinks about death most of the day every day. She needs several prompts every day before she will take a shower or brush her teeth.

Comagine Health

Discharge Planning

- Must begin upon admission, per federal and state regulations
- Updated with each review
- Includes specificity
- Family/guardian is actively involved
- Available lower level of care services being recommended and appropriate activity toward application

Comagine Health

Reporting Discharges

Report discharges via the Comagine Health Provider Portal or by phone after the recipient has discharged.

Submit the following information:

- The identified services recommended for follow-up care. Include considerations regarding:
  - Placement
  - Educational services and contact made
  - Individual, family and group psychotherapies, as well as other identified therapeutic interventions that may be needed at time of discharge, to include medication management and school supports
- The identified provider for services upon discharge
- The actual discharge date

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Late Submission Continued Stay Review Request

- Definition
- When to request it
- Required form
- Possible technical denial

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Delayed Eligibility Reasons for Late Submission Reviews:

- Definition
- May submit all at once to catch up to current date
  - Use the Admission Review questionnaire
  - Must include the Plan of Care
  - Divide the review into weekly increments with details of *daily acuity* in these weekly increments

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Payment is Contingent Upon

- Eligibility as determined by the Alaska Medicaid Program
  - Providers must call the Eligibility Verification System
    - (800) 884-3223 (24 hours/day, 7 days/week)
    - (800) 770-5650 in Alaska (8:00 am to 5:00 pm)
- Compliance with the rules and regulations that govern Medical Assistance in Alaska
- Completion of medical necessity prior authorization review

Incident Reporting Requirements

- Use correct Incident Report form based on level of care
- Follow incident reporting requirements
- Report critical incidents to the Alaska Department of Health and Social Services agencies (DHSS)
- May be required to submit the same incident report to multiple DHSS agencies

We Want to Hear from You

- How the review process works for you
- Any issues or concerns that may arise
- Additional ways Comagine Health can assist you
- Process improvement opportunities
- Individual training requests

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Questions and Answers



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Contact Information

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Closing Remarks – Conference Wrap Up

Yvette Stratton, RN, BSN, CCM

Executive Director, Care Management

Thank you for the services you provide to Alaska Medicaid recipients, and for your continued efforts on their behalf.

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Thank you for attending!

You will be receiving an email from UAA with instructions about a survey.

This will be related to the conference presentations you have attended.

Please complete the survey if you would like to receive continuing education units.

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