

Alaska State Hospital and Nursing Home Association

Acute Behavioral Health Improvement Project

Report and Recommendations for Positive
Change in Alaska's Communities and Hospitals

April 2019



ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION



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1. Project Purpose

Background

The Alaska State Hospital and Nursing Home Association (ASHNHA) requested funding from the Alaska Mental Health Trust Authority (Trust) to convene stakeholders to identify the goals and strategies to improve acute behavioral health services and address gaps and delays in the continuum of care. The project sought to develop solutions to re-align the system so that individuals receive proper treatment in the appropriate locations and programs and to identify strategies to intervene before patients present to emergency departments, and to provide appropriate follow up care. The target population for the project is individuals experiencing an acute behavioral health crisis, who seek services at an emergency department and could require admission to the Alaska Psychiatric Institute (API) or other inpatient psychiatric setting. The scope of the project is statewide.

Process + Intended Outcomes

- Convene stakeholders who have important perspectives on the issue and are able to take action to address it.
- As a group, identify and prioritize strategies that will result in a work plan that stakeholders agree to implement and advocate for.
- The work plan will prioritize solutions that will have a clear positive impact on the issue, can be implemented as soon as possible, and are within the power of the stakeholders to enact.
- The group will likely identify other longer-term solutions, including potential changes to laws or regulations, but implementation will focus on what can be done now.
- Agnew::Beck will summarize the group’s findings in a report, completed by February 2019.

Areas of Work

The project considers solutions at all levels, from organizational changes to statewide policy and systems changes, but the primary focus is on what ASHNHA members and partners can achieve in the short term.

Figure 1: Levels and Settings for Change



Stakeholder Workgroup

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

Each stakeholder was asked to consider and commit to the following:

1. Review and provide constructive feedback on ideas presented during the process, including reading materials shared in advance and actively participating in discussion.
2. Focus on practical, effective solutions that will improve the system for all parties: patients, health care providers and other staff, hospitals, and API.
3. Communicate back with your organization's leadership and other roles as appropriate, particularly when determining who will implement the proposed solutions.
4. Wherever feasible, identify how your organization can lead, participate in, and/or fund implementation of the resulting work plan as soon as possible.
5. For solutions that are longer term, require changes to law or regulation, and/or require additional funding or partnerships to execute, serve as a champion and supporter.

The organizations represented in the stakeholder group includes those listed below. Each organization on the list is deserving of special acknowledgement for the time and staff they set aside to prepare for and attend monthly meetings as part of this important project. A list of individuals who participated in the stakeholder group is located in Appendix A.

Alaska Behavioral Health Association (ABHA)

Alaska Department of Law

Alaska Native Medical Center (ANMC)

**American College of Emergency Physicians (ACEP),
Alaska Chapter**

Bartlett Regional Hospital

Cordova Community Medical Center

Mat-Su Regional Medical Center

Providence Alaska Medical Center

Providence Seward Medical Center

State of Alaska Public Defender Agency

Wrangell Medical Center

Alaska Department of Health and Social Services (DHSS)

Alaska Mental Health Trust Authority (the Trust)

Alaska Regional Hospital

Anchorage Community Mental Health Services (ACMHS)

Central Peninsula Hospital

Fairbanks Memorial Hospital

North Star Behavioral Health

Providence Kodiak Island Medical Center

Southeast Alaska Regional Health Consortium (SEARHC)

Veterans Affairs, Alaska Region

Yukon-Kuskokwim Health Corporation

Methodology for Recommendations

Stakeholder Discussions

Stakeholders convened seven times starting with an introductory webinar in September 2018 and culminating in a strategy prioritization session in January 2019. A follow up session with stakeholders was held in February 2019 to review the prioritized list of strategies. The focus of initial meetings was to provide an overview of the project, set project goals, and present local data available through Alaska's Health Facility Data Reporting (HFDR) system. Later meetings focused on presenting best practice and research from other states, sharing knowledge about changes and strategies being deployed in local health systems and generation of ideas for future change based on the experiences of local emergency departments and hospitals.

Guest presenters were invited to share their subject matter expertise with the workgroup, including:

- Representatives who participated in the Institute of Healthcare Improvement's innovative project *Integrating Behavioral Health in the Emergency Department and Upstream (ED and UP)* provided a summary of the goals of the project and the results they saw in the project's first phase.
- Kimberly Petit with Providence's Psychiatric Emergency Department provided an overview of the Psych ED's services, patient lengths of stay and discharge status.
- Quinlan Steiner and Linda Beecher with the Alaska Public Defender Agency provided a general overview of the civil commitment process and highlighted issues in statute and implementation.

During stakeholder discussions, participants identified possible strategies, which Agnew::Beck documented and categorized for the group's iterative review and evaluation.

Criteria for Strategy Prioritization

The following criteria were selected to evaluate potential strategies:

1. How **impactful** do you believe this will be to improve your ED and/or organization overall?
2. How **interested** are you in pursuing this action, within your organization and/or as a collaborative effort?
3. What **timeframe** does this strategy require: short term (zero to six months), medium term (six months to two years), long term (more than two years).
4. What is the **cost/benefit** to pursuing this action?
5. What **resources** would your organization need to support or implement this action?

Project Plan Development

The workgroup's master list of strategies was organized as identified in Figure 2 on the following page.

Figure 2: Workgroup Strategy Organization

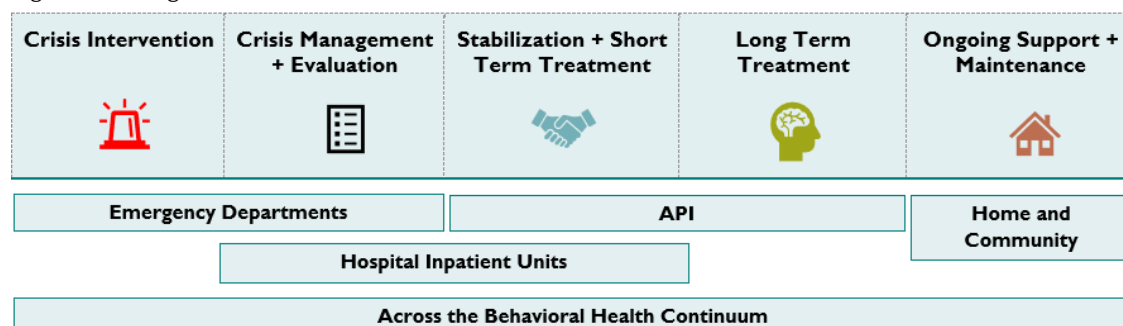
1. Hospital ED + Inpatient Settings
A. Standardize ED process from intake to discharge
B. Adopt trauma-informed approach and culture within the ED for patient care.
2. Hospital + Community Provider Collaboration
A. Increase and leverage hospital resources to fill system gaps.
B. Appropriately share patient care plans and data among EDs, hospitals and providers.
C. Increase care coordination with behavioral health providers.
3. Increase Capacity + Fill Gaps in Alaska’s Acute Behavioral Health Continuum of Care
A. Increase inpatient capacity in Alaska.
B. Expand home and community-based services, including crisis services.
C. Advocacy and funding priorities.
D. Legal and regulatory priorities.

Stakeholders had two opportunities to prioritize the identified strategies. First, a web-based survey was sent out to the group. Participants evaluated each strategy based on the criteria described above. Sixteen stakeholders responded to the online survey. Responses were tabulated, and strategies were ranked by perceived impact, level of interest in pursuing the strategy and perceived cost-benefit. Stakeholders were provided a list of resources for each of the identified strategies to use as a reference when completing the online poll. The list of strategies and associated resources are located in Appendix B.

The ranked strategies were presented for in-person discussion and live audience polling at the January 2019 workgroup meeting. At the meeting, stakeholders discussed each strategy before using Audience Response polling to vote on their top strategies under each action area.

Results from the online survey, online polling and participant feedback were incorporated to generate a list of prioritized strategies in multiple settings across the behavioral health continuum of care (Figure 3).

Figure 3: Settings Across the Behavioral Health Continuum



A complete list of strategies is summarized in the workgroup’s prioritization results in the January 2019 meeting, and can be found in Appendix C. The strategies listed in the Appendix identify the scores assigned to each strategy in the online survey and the number of votes each strategy received in the in-person meeting.

2. Defining the Problem

Psychiatric Boarding: Visible Symptom of a Systemic Problem

Psychiatric boarding refers to the increasingly common situation of patients in behavioral health crisis (including psychosis, schizophrenia, suicide ideation and other diagnoses) who present to the emergency department (ED) and are held at the hospital for several hours or days, without accessing the treatment they need in a more appropriate setting. The number of visits—and negative impacts of these visits on patients, families and staff—are increasing in Alaska and across the U.S. This growing problem has prompted hospitals, health care professionals and policymakers in several states to analyze the causes and impacts of boarding behavioral health patients, explore process and organizational changes within the ED to improve care for these patients, and develop an evidence-based theory of change for coordinated improvements to the overall continuum of care.

Psychiatric boarding is one visible symptom of larger problems in our health care system, particularly the gaps in the behavioral health continuum of care, including:

- Lack of standard processes within emergency department and inpatient settings to effectively triage, evaluate and treat behavioral patients in crisis;
- Lack of capacity in or access to community-based treatment options, due in part to inadequate funding and low Medicaid reimbursement rates for behavioral health services;
- Silos and limited communication between provider types, including lack of behavioral health capacity or expertise into the ED; and
- Lack of capacity within existing treatment facilities to provide effective longer-term treatment and reduce re-admissions due to frequent cycling through the system. In Alaska, the primary facility for adults is Alaska Psychiatric Institute (API), Alaska's only state psychiatric hospital.

Alaska's hospitals are already working to improve care within their facilities by investing in staff training, physical design, process improvements and other strategies to reduce psychiatric boarding. However, one of the primary findings of this workgroup is that internal improvements are not enough: a holistic view of behavioral health care across the continuum in Alaska is necessary to understand the problems and implement meaningful solutions. This includes:

- Strengthening community-based services to meet people's behavioral health needs, before and not only when they are in crisis;
- Alternatives to the ED, including crisis stabilization or other intervention services;
- Better coordination among providers to share information and treatment plans efficiently and deliver better patient-centered care;
- A functioning system of inpatient behavioral health care that delivers timely, effective treatment for those who need it, over a sufficient period of time to achieve meaningful results and with the goal of returning the patient safely to their community with access to ongoing supports.

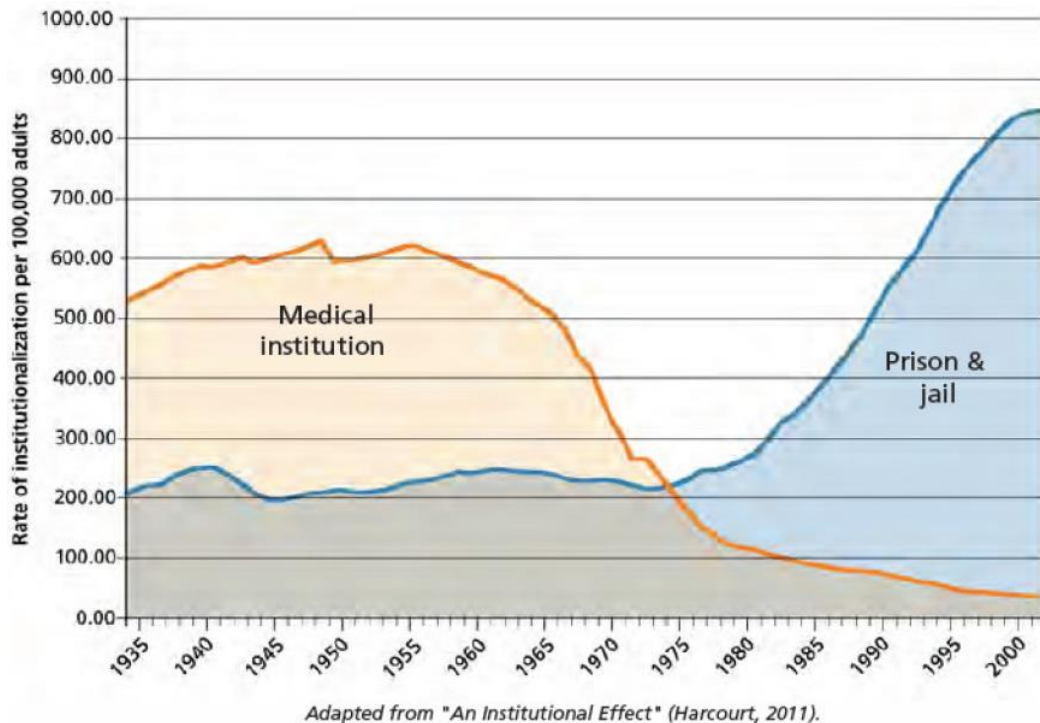
This section provides a brief overview of psychiatric boarding and related issues in Alaska, gaps and lack of capacity in our system that contributes to the problem, and relevant data from the state's Health Facilities Data Reporting (HFDR) database to characterize the issue in finer detail.

Unintended Consequences of De-institutionalization in the U.S.

One significant cause of the lack of community-based behavioral health services is the complex legacy of the de-institutionalization movement beginning in the 1960s, coinciding with creation of the Medicaid and Medicare programs and the Community Mental Health Centers Act (1963). Advocates for reform cited serious abuses of vulnerable patients at psychiatric institutions, and lack of opportunities for institutionalized persons to successfully live in their community and access care in less restrictive settings. The resulting legislation and programs created a national system of community mental health care intended to reduce or replace institutional care for as many people as possible.

Chronic underfunding of these services over subsequent decades and lack of integration into the medical system has hampered effective implementation of these laudable goals, and means that patients are not necessarily able to access needed care close to home. In addition, the rise of chronic homelessness, drug addiction and other complex social issues in the 1970s and beyond has resulted in greater rates of institutionalization not in medical, but correctional settings: the chart below, reproduced from a previous study, illustrates this fundamental shift in institutionalization patterns over the last 50 years. While this project does not address the relationship between mental illness and involvement with the criminal justice system, the continually decreasing rate of institutionalization in medical institutions in this chart reflects the concurrent trend that there is a shortage of inpatient psychiatric treatment beds compared with the need, without an accompanying increase in community-based services for the large majority of the population who can effectively be treated without institutionalization.

Figure 4: Location of Adults with Mental Illness: Medical Institution vs. Prison and Jail in the U.S., 1934-2001¹



¹ Reproduced from Cravez, Pamela. "Alaska's Lack of Psychiatric Beds and Consequences." University of Alaska Justice Center, May 21, 2018. Updated version of article originally published in Alaska Justice Forum 34:1 (2017).

National Trend: Emergency Departments See More Patients in Psychiatric Crisis

The problem of psychiatric boarding in hospital emergency departments has been well documented over the last decade: as early as 2010, an article published in *Health Affairs* cited a survey of ED medical directors about the issue, finding that 80% of respondents believed that psychiatric patients were being boarded in their facilities. The Institute for Health Innovation (IHI)'s 2018 report on this issue cited more current national statistics based on their literature review:

- **1 in 5** ED visits are related to a primary behavioral health diagnosis.
- EDs have seen a **44% increase** in acute behavioral health visits between 2006 and 2014.
- Within this patient population, **vulnerable people are disproportionately represented**: low income individuals, Medicaid enrollees, and individuals with mental health diagnoses including depression, anxiety disorders and schizophrenia.
- Behavioral health patients stay in the ED approximately **3 times longer** on average than those with a medical diagnosis.
- These longer stays impact the ED's overall capacity: ED bed turnover time is approximately **twice as long** for these patients, and staff spend more time locating an available inpatient bed so they can be transferred from the ED to a more appropriate setting.
- This bottleneck of behavioral health patients in the ED is driven by a lack of inpatient psychiatric treatment beds, combined with a lack of community based behavioral health services and inadequate funding for these services nationwide, leaving nowhere else to go.²

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

While there are many ways to improve other parts of the behavioral continuum of care with the goal of alleviating pressure on the ED, these studies also conclude that EDs must expect to continue seeing patients in psychiatric crisis and treat them more effectively. Efforts in other states have focused on how EDs can make internal improvements or investments to meet this demand, even as other strategies are pursued to prevent escalation to psychiatric crises and/or divert patients to more appropriate care settings. This requires a significant culture shift for EDs and hospitals, whose traditional role has been in treating acute medical conditions and connecting patients with other care or discharging them as soon as safely possible.

The workgroup's recommendations, outlined in Section 4, accept the assumption that EDs will continue serving psychiatric patients on a regular basis, and therefore follow a two-part approach for improving care within the ED, and strengthening the continuum of care overall.

² Cited in Laderman M, Dasgupta A, Henderson R, Waghay A, Bolender T, Schall M. *Integrating Behavioral Health in the Emergency Department and Upstream*. IHI Innovation Report. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

Alaska's Behavioral Health System Is Fragmented and Increasingly Stressed

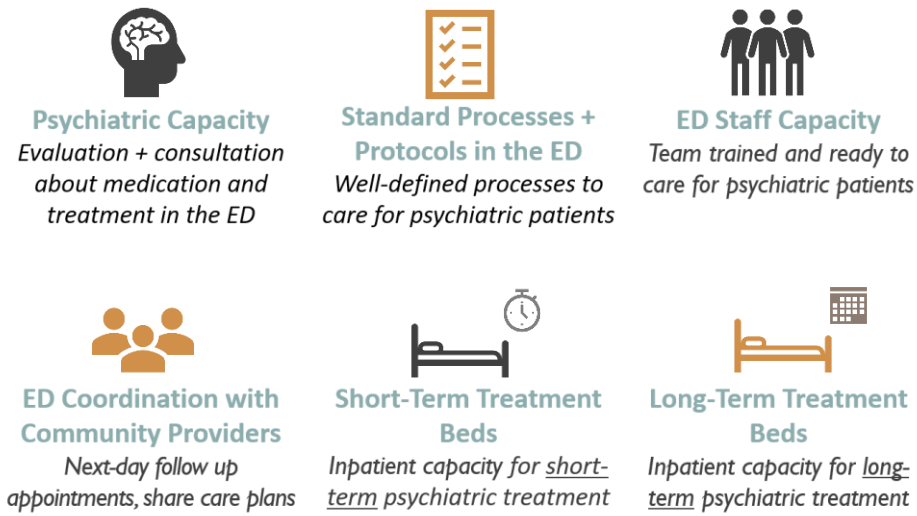
Reviewing the national literature and other states' work on the issue of psychiatric boarding, many of the statistics and systemic gaps aligned closely with Alaska hospitals' experience: without appropriate behavioral health care in community-based or inpatient treatment settings, patients in crisis are kept in emergency departments or non-psychiatric inpatient units or discharged home without a referral to the treatment they need. While other states' experiences indicate that this is a serious and urgent problem across the country, Alaska's overall lack of behavioral health services across the continuum of care—from crisis stabilization as an alternative to the ED, to inpatient psychiatric treatment beds, to community based (outpatient) behavioral health services for non-emergency care and ongoing maintenance to avoid another crisis—compounds this problem significantly and has resulted in increasing strain on emergency departments in particular.

Additionally, the involuntary civil commitment process (ex parte or Title 47 order) is increasingly utilized because it is perceived as the only feasible avenue to access care for patients in crisis, an effect of API's admissions policy for civil cases, changed in 2009-2011 to discontinue accepting peace officer or emergency admissions and voluntary admissions, and accept only involuntary admissions. This policy change has resulted in a large increase in the number of involuntary commitment cases over the last decade. Further straining the system in 2018 was API's ongoing staffing and capacity issues, resulting in periodic closures of units and even a hold on all new admissions until there was adequate staff to serve patients in the facility.

While API as a facility has capacity for 80 beds, including 10 beds designated for forensic rather than civil patients (Taku unit) and 10 beds designated for adolescents (Chilkat unit), this combination of capacity challenges as well as unit closures for renovation has resulted in actual utilization of the facility at lower numbers, as low as 24 beds (out of 60) for civilly committed adults in 2018. API's policy decisions to provide short-term stabilization to meet this high demand, rather than longer-term treatment of fewer individuals, has also resulted in several individuals cycling in and out of its facility and other settings, reflected in API's low average length of stay and high readmission rates compared to peer hospitals. Because it is so difficult to get admitted to API let alone treated over a sufficient period of time to have lasting positive outcomes, those who have the most acute need for treatment, and who may be appropriately served at Alaska Psychiatric Institute if they have been evaluated as needing civil commitment, are those most likely to be waiting for hours or days in the ED because API cannot admit them.

Figure 5 illustrates the major categories of critical gaps identified by the workgroup, all of which need to be addressed or have their capacity increased.

Figure 5: Critical Gaps in Alaska’s Acute Behavioral Health Continuum of Care: What’s Missing Today?



These gaps are specific to the issue of psychiatric boarding, and do not sufficiently illustrate the overall system-wide gaps in the entire continuum, particularly outpatient services and alternatives to the ED such as a crisis stabilization center. The graphic also does not illustrate the local differences in these gaps: in general, urban communities in Alaska have more population, more resources but also more demand for those resources. Rural communities, both hub communities and outlying villages, may lack most or all services on the continuum, as well as not having sufficient demand to invest in a psychiatric unit, meaning they cannot meet the needs of even a smaller number of people who enter the system locally needing acute behavioral health care.

There are other hospitals in the state designated to provide evaluation and treatment (DET hospitals), funded through the state’s allocation of Disproportionate Share Hospital (DSH) funding: Fairbanks Memorial and Bartlett Hospital in Juneau have 20 and 12 beds, respectively, and provide evaluation and stabilization services. There is also a psychiatric emergency department at Providence in Anchorage, a seven-bed unit that accepts adults for voluntary commitment; North Star Behavioral Health in Anchorage maintains inpatient beds for voluntary committed youth needing psychiatric treatment. More hospitals have begun investing in additional beds for short-term psychiatric treatment, as well as resources for behavioral health staff or consultation via telehealth in the ED, training for ED staff in how to work with behavioral health patients, and policy and process changes to better support the needs of these patients. While these existing inpatient beds address some of the need and these additional investments will help, the systemic gaps in Alaska’s behavioral health continuum of care must also be addressed to make meaningful change.

Quantifying and Characterizing the Problem: Review of Alaska Data

One significant gap in Alaska’s understanding of the issue was a review of available data to characterize the scope and characteristics of the problem. ASHNHA identified a recent data analysis project in Arizona that provided a useful framework for this project. The Arizona Department of Health Services report, *Access to Psychiatric Inpatient Care: Prolonged Waiting Periods in Medical Emergency Departments* (2014; updated 2017) compiled a data report for extended ED visits in their state from

2012 to 2014. The resulting data illustrated the growing issue of psychiatric boarding in that state, including more detailed information by diagnosis code, county, patient demographics and payer mix. The Arizona Hospital and Healthcare Association utilized this data to develop recommendations to reduce the problem in their state.

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

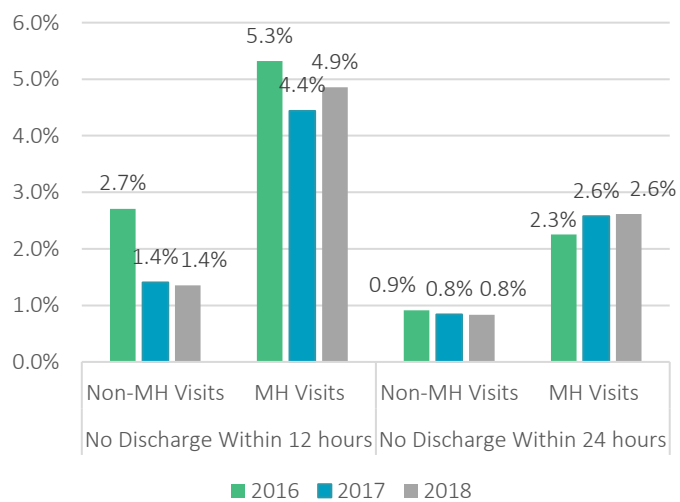
Based on a review of Arizona’s report, ASHNHA requested HFDR data from DHSS to identify data that would illustrate the current situation and trends in psychiatric boarding in Alaska’s hospital emergency departments. The Alaska data request used the same ICD-9 and ICD-10 codes as the Arizona report, with subsequent adjustments to the parameters to better reflect Alaska’s experience based on questions and concerns voiced by workgroup participants in the initial data findings. The project team and DHSS added additional diagnosis codes, reviewed both primary and secondary diagnoses at discharge, and requested a second set of data characterizing the population who was transferred to an inpatient psychiatric facility or unit after discharge from the ED.

Data presented in this version of the report is for calendar years 2016, 2017 and 2018.

Key Findings: Behavioral Patients Presenting to Emergency Departments

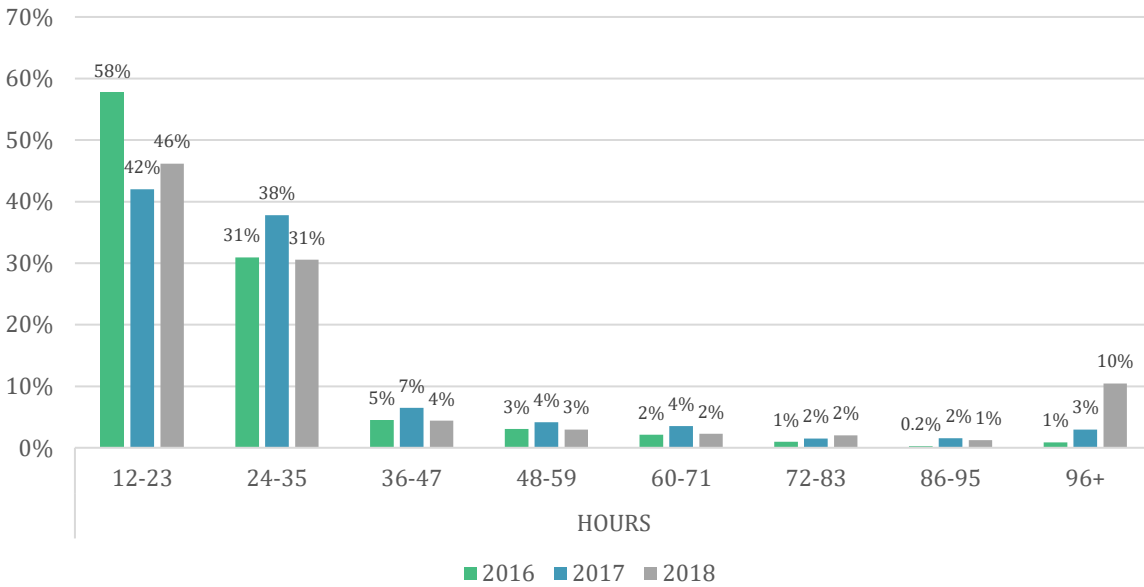
- Approximately 1 in 4 patients have a primary or secondary behavioral health (BH) diagnosis, and this number has increased since 2016.
- Approximately five percent have stays longer than 12 hours.
- Behavioral health patients are twice as likely to have ED stays more than 12 hours, and are more than twice as likely to have ED stays more than 24 hours, when compared to those in the ED who do not have a BH diagnosis (Figure 6).
- Most behavioral health patients seen in EDs for stays of 12 or more hours are discharged to home/self-care. The number of behavioral health patients discharged to psychiatric hospitals decreased from 17 percent in 2017 to just eight percent in 2018.
- On average, patients are waiting longer and a small but growing number are waiting more than 156 hours (6.5 days). This trend has grown worse over time: In 2016, just two behavioral health

Figure 6: All ED patients not discharged within 12 and 24 hours



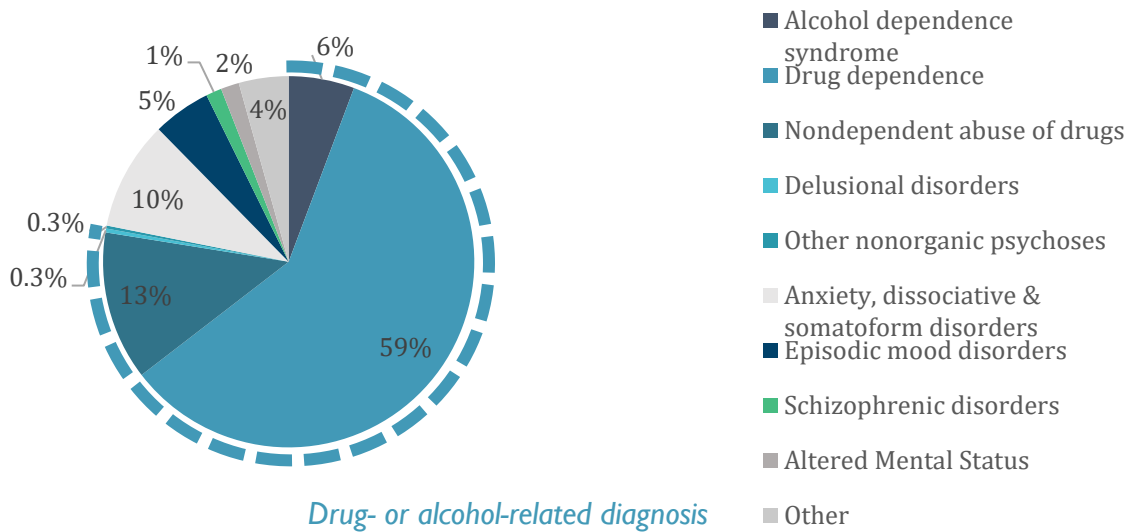
patients spent over six days in an ED. In 2018, the number of behavioral health patients spending over six days in an ED grew to 125 (Figure 7).

Figure 7: Percentage of behavioral health ED stays lasting 12 hours or more



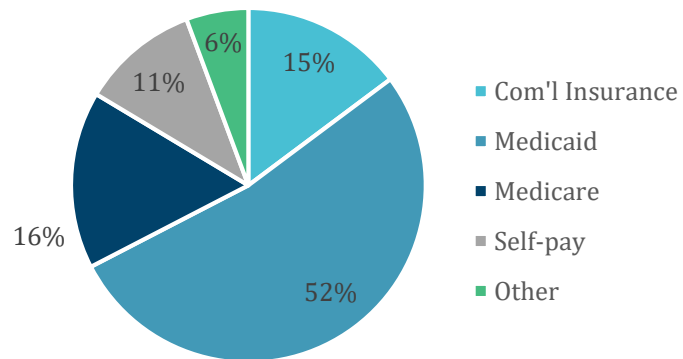
There are two distinct trends in diagnoses of those presenting to the ED with a behavioral health issue (Figure 8). First, a large volume of individuals are in the ED, four out of five (approximately 78 percent in 2018) have an alcohol or drug-related diagnosis, including alcohol dependence, drug dependence, nondependent abuse of drugs. This group stays only four hours on average, but accounts for most of the ED’s volume of behavioral health patients (approximately 39,983 patients in 2018). Second, a small number of patients, less than one percent in 2018, tends to be the specific population waiting for several hours or days for safe transfer to another facility or safe discharge. Patients with delusional disorders and other nonorganic psychoses have the longest ED stays, but are a very small number of BH patients (0.6 percent, or 308 patients in 2018).

Figure 8: Percentage of ED patients by behavioral health diagnosis category, 2018



In 2018, over half of behavioral health visits in the ED indicated Medicaid as the primary payer; this increased from 46 percent in 2016 and may reflect increased enrollment in Medicaid over time, as a result of Alaska’s implementation of Medicaid expansion in September 2015 (Figure 9). In 2018, Medicaid was the payer in 52 percent of behavioral health ED visits. Self-pay decreased over the same time period, down to 11 percent from 16 percent in 2016, also potentially reflecting increased Medicaid enrollment of previously uninsured patients. Additionally, 15 percent of patients in this population are covered by commercial insurance, and 16 percent are covered by Medicare.

Figure 9: 2018 Emergency Department Behavioral Health Visits, by Payer



Key Findings: Patients, Regardless of Diagnosis, Transferred to a Psychiatric Facility

After discovering in the data a distinct population who was discharged to a psychiatric facility, the project team also analyzed the characteristics of this population to understand if there were meaningful differences in the general population compared with those who were committed for some period of time. Discharge from emergency departments within 12 or 24 hours is less likely for behavioral health patients who transfer to a psychiatric facility than for those who do not:

- In 2018, only 37.3 percent of behavioral health patients transferred from emergency departments to a psychiatric facility did so within 24 hours.
- The data indicates that boarding of patients needing psychiatric hospitalization is worsening, as the ability of these patients to be discharged to a facility within one day (24 hours) has decreased almost 25 percent since 2016 although a slight increase in discharges within 24 hours is noted between 2017 and 2018.
- For behavioral health patients on inpatient units who are discharged to psychiatric facilities, individuals with schizophrenic disorders stay the longest. Individuals with schizophrenia awaiting discharge to a psychiatric facility comprised four percent of behavioral health patients on inpatient units and were boarded for an average of 8.1 days in 2018, and as high as an average of 18.7 days in 2017.

Behavioral health patients held on inpatient units also experience long waits for discharge to psychiatric facilities (Figure 10 and Figure 11):

- In 2018, 80.9 percent of behavioral health patients on inpatient units discharged to a psychiatric facility within 10 days, but the remaining 19.1 percent of patients took 10 or more days to discharge.
- For patients requiring transfer to a psychiatric facility from an inpatient unit, 65 percent are held for two to nine days before transfer, while only 8 percent are transferred within one day.

Figure 10: Behavioral health ED patients discharged to a psychiatric facility within 12 and 24 hours

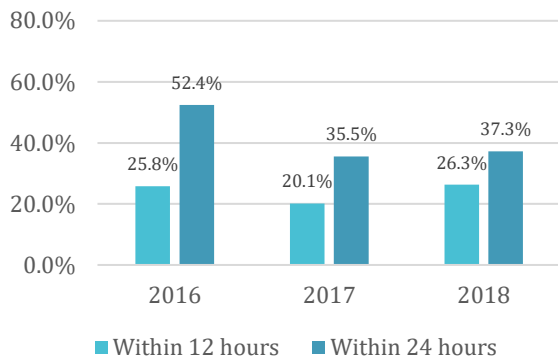
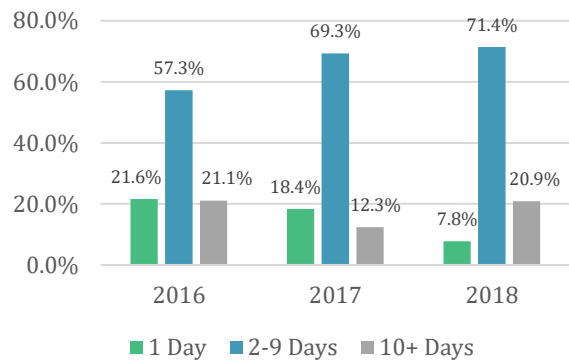


Figure 11: Percentage of inpatient unit transfers to psychiatric facilities/units by number of days



Patients transferred to a psychiatric facility or unit spend significantly longer in the ED than the overall behavioral health population, but in 2018 the average time increased significantly, regardless of diagnosis (except for altered mental status). The average number of hours spent in the ED awaiting transfer to a psychiatric facility increased from 27.1 hours in 2016 to 41.9 hours in 2017. From 2017 to the first half of 2018 the average wait time for transfer to a psychiatric facility for all diagnoses more than doubled to 88.3 hours. Individuals with schizophrenic disorders, other nonorganic psychoses and delusional disorders spent the longest amount of time in emergency departments, regardless of whether they were transferred to a psychiatric facility, but also had the highest average stays (Figure 12).

Figure 12: Average hours in ED, by diagnosis type

Diagnosis Group	All Behavioral Health Patients			Transferred to Psych Facility		
	2016	2017	2018	2016	2017	2018
<i>Average Hours in ED, by Diagnosis Type</i>						
Alcohol dependence syndrome	4.6	4.2	4.6	NA	35.7	20.0
Altered mental status	6.5	6.2	6.3	38.3	44.0	73.0
Anxiety, dissociative + somatoform	4.3	4.3	4.8	23.9	34.8	67.4
Delusional disorders	10.5	9.6	20.9	24.2	30.2	126.3
Drug dependence	3.6	3.6	4.0	27.0	45.2	88.0
Episodic mood disorders	5.8	6.7	8.7	26.6	31.4	82.8
Nondependent abuse of drugs	4.9	4.6	4.9	23.9	45.2	79.7
Other nonorganic psychoses	12.4	19.7	25.7	32.4	58.0	146.7
Schizophrenic disorders	6.8	7.7	9.6	31.9	54.1	151.1
All mental health diagnoses	4.2	4.1	4.8	27.1	41.9	88.3

Involuntary Civil Commitments

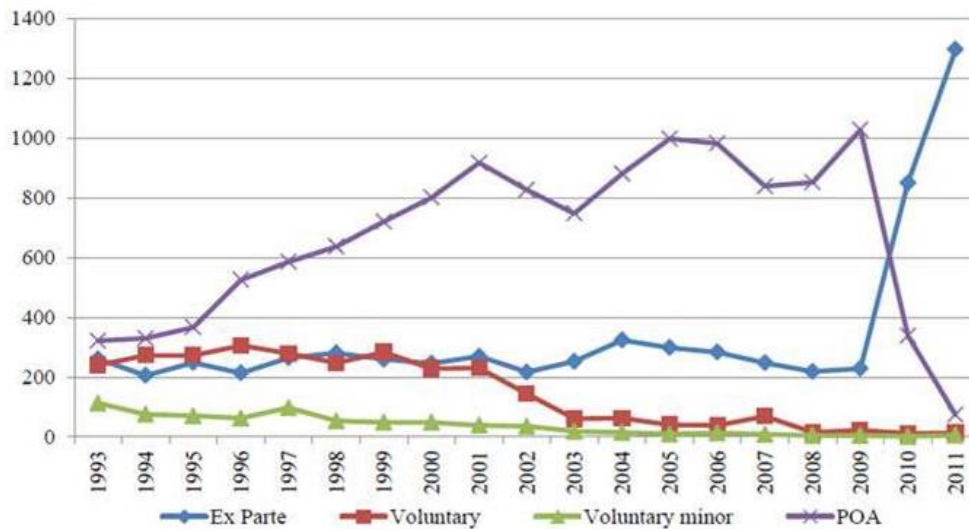
Civil commitments are a type of probate (non-criminal) cases, which fall under the jurisdiction of the Alaska Superior Court. The overall percentage of Superior Court filings that are probate cases increased roughly 10 percent over the last ten years. The percentage of probate filings that are civil commitments increased roughly 20 percent in the same period, indicating an increase in handling civil commitment orders as a growing proportion of the Superior Court’s work.³

There are twelve categories of admission to the Alaska Psychiatric Institute (API), with the four most common over time depicted in Figure 13. The four most common categories are:

- Involuntary commitment for evaluation under AS 47.30.700, a 72-hour involuntary commitment for evaluation, including evaluation of whether a longer-term commitment should be sought, known as an “ex parte order” or simply “ex parte;”
- Involuntary commitment via emergency detention under AS 47.30.705, known as a “peace officer application” because it can be initiated by a peace officer or mental health professional; and
- Voluntary adult admission
- Voluntary minor admission

The other eight categories are infrequently used and make up zero to four percent of admissions across years in the University of Alaska Anchorage Center for Behavioral Health Research and Services study period. The less frequently used categories are: Court ordered evaluation, correctional transfers, Title 12 (incompetent to stand trial), Title 12 (not guilty by reason of insanity), court placement, return from early release and return administrative discharge.⁴

Figure 13: Number of annual API Admissions by type, 1993 to 2011⁵



³ Alaska Court System Annual Reports, FY 2007-FY 2017.

⁴ UAA Center for Behavioral Health Research & Services, *Emergency Mental Health Services Utilization Project: Current and Historical Admissions Patterns at Alaska Psychiatric Institute*, CBHRS EMHS Technical Report No. 1, 2012.

⁵ Chart reproduced from UAA Center for Behavioral Health Research & Services, *Emergency Mental Health Services Utilization Project: Current and Historical Admissions Patterns at Alaska Psychiatric Institute*, CBHRS EMHS Technical Report No. 1, 2012.

Admissions by Peace Office Application (POA) steadily increased since 1993, making up over 70 percent of admissions by 2009, at which point API made a policy decision to no longer accept POAs. Ex parte admissions were much less common by comparison and occurred at a stable rate until 2009. After this admissions policy decision went into effect in 2009, ex parte orders began to rise as the most viable legal avenue to secure an involuntary commitment for an individual in crisis. Voluntary admissions have always made up a very small proportion of API admissions, representing at most 10 percent of all admissions in the 1990s. In the early 2000s, voluntary admissions to API virtually disappeared.⁶

The increase in ex parte orders from FY 2008 to 2018 is show in Figure 14 below. The significant increase in 2010 to 2011 corresponds to the changes to API admission policy initiated in 2009 and another significant, but smaller increase in number of orders is seen from 2017 to 2018.

Figure 14: Ex Parte Orders, Fiscal Years 2008 to 2018⁷

Year	# Ex Parte Orders	1 Year Change (#)	1 Year Change (%)
2008	511	N/A	N/A
2009	600	89	17%
2010	1,008	408	68%
2011	1,330	322	32%
2012	1,891	561	42%
2013	2,108	217	11%
2014	2,003	(-105)	(-5%)
2015	2,135	132	7%
2016	2,119	(-16)	(-1%)
2017	2,321	202	10%
2018	2,529	208	9%

Stakeholders participating in the workgroup shared that these admissions decisions have impacted decision-making in the health care system for these patients, including patients who would otherwise consent to a hold for evaluation or for a longer-term commitment. Because there are limited options for inpatient psychiatric treatment throughout the state, particularly for adults, the ex parte process currently represents the only viable option for accessing evaluation, stabilization and treatment services, as it opens access to the evaluation services at API and other designated facilities who receive involuntary commitments. As a result, it is impossible to conclude from this data whether the number of orders reflects the number of individuals who strictly meet the thresholds required for an ex parte order, and whether the patient would have otherwise consented to commitment and treatment if access to voluntary commitment was a viable option at that time. The historical increase in ex parte orders does correlate with API's decision to change its admission policy. The more recent increase is more

⁶ UAA Center for Behavioral Health Research & Services, *Emergency Mental Health Services Utilization Project: Current and Historical Admissions Patterns at Alaska Psychiatric Institute*, CBHRS EMHS Technical Report No. 1, 2012.

⁷ Alaska Court System data request, November 2018. The data includes orders initiated, and does not indicate whether each order was granted, denied or rescinded due to the patient no longer meeting the criteria for involuntary commitment.

difficult to accurately characterize but may be related to lack of inpatient psychiatric treatment overall, and providers' increased use of this legal process to help patients access care.

Complex Costs of Psychiatric Boarding

While it is difficult to quantify the cumulative costs of this problem, the costs are multi-faceted:

- **Opportunity costs in resource allocation** for both the public and private sectors. This means less capacity in the ED to respond to medical emergencies, increased utilization of law enforcement and emergency response personnel, increased utilization of the court system to secure involuntary commitment orders for people in crisis, payment for care and/or boarding in a high-cost setting that is not appropriate for the patient's actual needs, and a cycling of many patients through these systems without ever receiving effective treatment or referral to outpatient resources for their condition.
- **Financial costs** to hospitals in the form of lower bed turnover and waiting hours, uncompensated and non-billable care, damage to equipment and facilities by disruptive patients, and the legal and administrative problems that hospitals must spend resources to address.
- **Efficiency costs** for EDs to triage and direct patients to the appropriate care setting, including a lack of standardized processes for assessing and treating behavioral health patients, compared with well-defined processes for medical conditions.
- **Workforce costs** for hospitals and staff struggling to manage overwhelmed EDs, resulting in reduced productivity, staff injuries, reduced morale and increased turnover. ED staff typically do not have behavioral health training during their medical education, do not have access to the tools or expertise that would help them diagnose and treat behavioral health conditions, and lack training in best practices for effectively working with behavioral health patients, such as verbal de-escalation in place of seclusion and restraints to reduce the patient's agitation and increase cooperation.
- **Most importantly, human costs** for patients, their families, ED and hospital staff, and the community at large. The gaps in our current system mean that some patients become more agitated or remain in crisis longer, wait for long periods in a setting not designed to help them, do not receive adequate care, and are discharged with no effective plan for long-term improvement. That patients' families and loved ones, concerned for their well-being or actively trying to help them access treatment, have limited options and are often not informed or involved in care planning. That other patients and their families in the ED That ED staff and first responders, trained to triage and stabilize people in medical crisis, must struggle to provide care without the tools they need to do so, leading to stress and feelings of helplessness in an already stressful environment.

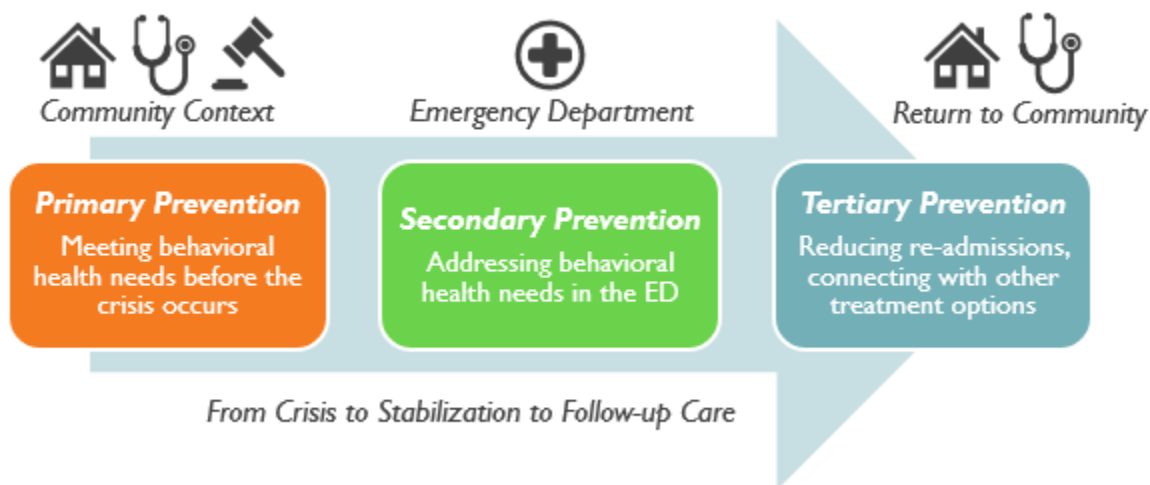
3. Finding Solutions

Theory of Change

Three Opportunities for Prevention

Opportunities for prevention of extended stays in emergency departments for those with behavioral health needs were identified across all three levels of prevention (Figure 15). Primary prevention in this context includes efforts that happen in the community context, such as community-based treatment, care coordination and diversion to other settings where appropriate. Secondary prevention activities focus on addressing the behavioral health needs in the ED through the standardization of intake, assessment and treatment protocols and the introduction of a trauma-informed culture. Tertiary prevention includes activities that aim to reduce readmissions such as standardized discharge protocols, discharging to the appropriate setting and follow-up and referrals to community-based providers.

Figure 15. Prevention at Each Stage of a Behavioral Health Crisis⁸



Institute of Healthcare Improvement Innovation Report

The Institute for Healthcare Improvement (IHI) published a report in 2018 entitled Integrating Behavioral Health in the Emergency Department and Upstream. Recognizing that psychiatric boarding is a national issue, IHI sought to:

1. Identify gaps in care for individuals with behavioral health needs that present to the ED and best practices to fill those gaps; and
2. Develop a theory of change, including specific change ideas to integrate behavioral health care into emergency departments.⁹

⁸ Arizona Hospital and Healthcare Association. *Waiting for Care: Causes, Impacts and Solutions to Psychiatric Boarding in Arizona*. July 2015.

⁹ Laderman M., Dasgupta A., Henderson R., Waghray, A., Bolender T., Schall, M. *Integrating Behavioral Health in the Emergency Department and Upstream*. IHI Innovation Report. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

Through the innovation project, IHI discovered that behavioral health care is not integrated in to emergency departments in most health systems across the country and that many of the programs that do exist focus on just one part of the system, leading to fragmented services.¹⁰

IHI’s innovation project identified five primary drivers of change. The ASHNHA Acute Behavioral Health Improvement Project workgroup added a sixth driver “expand or modify system of care” to capture the need for changes across the behavioral health continuum of care that are not represented by the other drivers. The theory of change was presented to the workgroup and identified the level of intervention each driver influences (Figure 16).

Figure 16: Theory of Change¹¹

	Primary (before presenting)	Secondary (when at the ED)	Tertiary (reduce re-admission)
1. Build and leverage partnerships with community-based services.	✓		✓
2. Coordinate and communicate between the ED and other health care and community-based services.	✓	✓	✓
3. Standardize processes from ED intake to discharge for a range of behavioral health issues.		✓	
4. Engage patients and family members to support self-management following ED discharge.		✓	✓
5. Create a trauma-informed culture among ED staff.		✓	
6. Expand or modify system of care.	✓	✓	✓

IHI’s work goes beyond development of a theory of change to providing support to 8-10 health systems to test best practices, evaluate outcomes and develop scale-up plans to bring proven improvement strategies to other hospitals and health systems. Participating health systems focused on standardizing processes around intake and assessment, development of observation units or therapeutic waiting areas, increasing collaboration with community partners, changing facility culture to become more trauma informed and improving or implementing post-discharge follow up. Preliminary results from participating facilities include:

1. Reduction in boarding volumes for facilities that implemented observation units.
2. Reduction in the number of violent episodes requiring the use of restraints for facilities that provided trauma informed trainings for staff.
3. Reduction in length of stay for facilities that offered psychiatric consults in the ED and were able to provide medication at discharge.¹²

¹⁰ Laderman M., Dasgupta A., Henderson R., Waghray, A., Bolender T., Schall, M. *Integrating Behavioral Health in the Emergency Department and Upstream*. IHI Innovation Report. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

¹¹ Adapted from: Laderman M., Dasgupta A., Henderson R., Waghray, A., Bolender T., Schall, M. *Integrating Behavioral Health in the Emergency Department and Upstream*. IHI Innovation Report. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

¹² Institute for Healthcare Improvement. *Friends of ED & UP Quarterly Webinar Presentation*; November 29, 2018.

INNOVATION IN ACTION

West Tennessee Healthcare brought together community stakeholders to develop and implement what would become a five-pronged plan to reduce hospital emergency department visits for individuals with behavioral health issues and improve access to services. Strategies employed by the collaborative reflect priorities of the ASHNHA workgroup and other state level priorities. The Tennessee collaborative:

- Improved **integration with the medical community** by adding a crisis walk-in center and crisis stabilization unit on its main campus, near the emergency department and added behavioral health clinics in primary care physician offices. *Integration of behavioral health and primary care was identified as a top priority by the ASHNHA workgroup.*
- Collaborated with **law enforcement and first responders** to provide Crisis Intervention Team training, mental health and recovery courts and other tailored services to reduce agitation and stigma in behavioral health patients. *Discussion of community-based crisis services (EMS, law enforcement, Assertive Community Treatment, Crisis Intervention Teams) were an important part of ASHNHA workgroup discussions.*
- **Trained the community to administer Naloxone** to empower community members to save lives. *Current initiative of Alaska's Office of Substance Misuse and Abuse Prevention (OSMAP).*
- Created a space to **treat pregnant women with substance use disorders** by partnering with a local recovery center. *Pregnant women are a priority population for treatment for many Alaska Division of Behavioral Health grants.*
- Implemented **telehealth** to improve access to care, to fill a need that exists due to a shortage of psychiatrists and psychiatric hospital beds. *Identified as a top priority by the ASHNHA workgroup.*

The collaborative saved more than 42,000 jail days, a cost-savings of nearly \$1.5 million and decreased the number of acute care ED visits and involuntary mental health commitments.

Source: Schmidt, T. *West Tennessee Healthcare collaborative improves behavioral health patients' access to care, reduces stigma.* American Hospital Association; 2018.

Project BETA: Best practices in Evaluation + Treatment of Agitation

Agitated individuals are at risk of becoming aggressive and violent and agitation is a leading cause of hospital staff injuries.¹³ The American Association for Emergency Psychiatry recognized a need to develop best practice protocols to address agitation in emergency departments to promote staff and patient safety and thus convened five study workgroups to establish best practice guidelines for the agitated patient, including: medical evaluation and triage, psychiatric evaluation, verbal de-escalation, psychopharmacologic approaches, and use and avoidance of seclusion and restraint. Each workgroup used the treatment goals of emergency psychiatry to guide development of best practice strategies. Collectively, these guidelines are called Project BETA (Best practices for the Evaluation and Treatment of Agitation).

Through literature review and consultation with experts in the field, five articles were written with guidelines and recommendations for each topic area. Selected findings include:

1. The use of verbal de-escalation helps patients regain control and participate in treatment.¹⁴
2. Reduced use of restraints leads to quicker and less traumatizing de-escalation, fewer injuries to patients and staff, shorter boarding times, and other positive outcomes for patients, staff and facilities.¹⁵

EMERGENCY PSYCHIATRY TREATMENT GOALS

1. Exclude medical etiologies for symptoms
2. Rapid stabilization of acute crisis
3. Avoid coercion
4. Treat in the least restrictive setting
5. Form a therapeutic alliance; and
6. Appropriate disposition and after-care plan.

Source: Holloman, G. H. Jr., Zeller, S. L. *Overview of Project BETA: Best practices in Evaluation and Treatment of Agitation*. Western Journal of Emergency Medicine; 2011.

Emerging Solutions in Alaska

Integration of Behavioral Health and Primary Care

In Anchorage, health systems are moving towards the integration of behavioral health and primary care. The Providence Family Medicine Center integrates behavioral health in to the primary care setting and Southcentral Foundation, through their Nuka System of Care, offers behavioral health consultation and case management support as part of a primary care team.

¹³ Gates D.M., Ross, C.S., McQueen, L. *Violence against emergency department workers*. Journal of Emergency Medicine. 2006; 31: 331-337.

¹⁴ Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H. Jr., Zeller, S. L., Wilson, M. P., Rifai, M. A., Ng, A. T. *Verbal de-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup*. Western Journal of Emergency Medicine; 2011.

¹⁵ Knox, D. K., Holloman G. H. Jr. *Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup*. Western Journal of Emergency Medicine; 2011.

Access to Telepsychiatry

The Providence Psychiatric Emergency Department is launching telepsychiatry in early 2019 with the potential to extend this service to the critical access hospitals in their system. Petersburg Medical Center has a contract with a telepsychiatry group out of Montana that is expected to start in 2019.

Initiation of Medication Assisted Treatment in the ED

Bartlett Regional Hospital in Juneau started a program to initiate medication assisted treatment (MAT) for emergency department patients with opioid abuse issues. Patients get one suboxone treatment in the emergency department and are connected to follow up outpatient appointments. Patients may return to the ED for additional treatments until their outpatient appointment.

4. Recommendations + Work Plan

Primary Recommendations



Emergency departments (EDs) are well situated to provide crisis intervention, management and evaluation services. **Investment in facility, process, staffing and intervention changes** are needed so EDs can effectively and appropriately respond to behavioral health patients.



Hospital inpatient units are ready and willing to invest in stabilization and short-term treatment for behavioral health patients but require a **stable policy and reimbursement environment** to plan for a financially viable treatment setting.



Advocate for API to provide **acute and longer-term treatment** in a safe and secure setting while promoting practices that reduce recidivism.



Fund a full range of home and community-based services, which are less expensive than acute and inpatient services and provide behavioral health patients with care in the least restrictive setting.



Remove barriers to treatment and information sharing by developing a shared tele-psychiatry contract and implementing EDie across hospital, behavioral health and primary care systems.

Recommendations Across the Behavioral Health Continuum of Care

The first graphic on the following pages identifies the workgroup's recommendations by setting across the behavioral health continuum of care. The strategies under each setting are in the order prioritized by the stakeholder workgroup.

Recommendations for Improving Care in the Emergency Department

A review of best practice research and stakeholder discussion generated a list of strategies emergency departments can implement to improve patient care throughout their admission. Opportunities exist for hospitals to improve care for behavioral health patients from the intake and triage process through discharge. The second graphic on the following pages identifies specific strategies.

Strategies to Strengthen Alaska's Continuum of Acute Behavioral Health Services

Recommendations of the ASHNA Acute Behavioral Health Workgroup, February 2019

<p>Crisis Intervention</p> 	<p>Crisis Management + Evaluation</p> 	<p>Stabilization + Short Term Treatment</p> 	<p>Long Term Treatment</p> 	<p>Ongoing Support + Maintenance</p> 
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Emergency Departments

1. Improve process for post-discharge follow-up
2. Increase designated observation units in EDs and inpatient
3. Guide implementation of Project BETA best practices
4. Hire psychiatric nurses and/or mental health aides in EDs
5. Initiate Medication Assisted Treatment in EDs
6. Implement brief intervention protocols (SBIRT) in EDs
7. Expand psychiatric ED model in Anchorage and Mat-Su

API

1. Advocate for API to provide both acute and longer-term treatment in a safe and secure setting.
2. Increase average length of stay and reduce recidivism to API.

Home and Community Settings

1. Secure agreements for next-day behavioral health follow-up appointments post-ED.
2. Create a behavioral health Medicaid high utilizer program, with required participation
3. Increase step-down programs to avoid discharge back to homelessness: permanent supportive housing, group homes, recovery support
4. Increase intensive case management and assertive community treatment (ACT)
5. Advocate for integration of behavioral health services in primary care settings
6. Advocate for additional provider types to bill Medicaid.

Hospital Inpatient Units







1. Identify a reliable Medicaid reimbursement methodology for hospitals to increase inpatient capacity for short-term treatment.
2. Advocate for a stable policy and reimbursement environment.
3. Develop a statewide triage system for transfers of civil involuntary commitments to API to ensure highest acuity prioritized for transfer.
4. Staff hospitals with case managers to coordinate, help access resources.
5. Evaluate and potentially revise the Mental Health Treatment Assistance Program to optimize resources for treatment beds and secure transport.

ACROSS THE BEHAVIORAL HEALTH CONTINUUM

1. Develop a shared tele-psychiatry contract among hospitals for psychiatric consults in ED and inpatient units. Remove barriers to licensing for providers.
2. Implement use of EDie across hospital, behavioral health and primary care providers, starting with addressing API's barriers to using EDie.
3. Evaluate the need for changes to Alaska statutes regarding civil commitment, length of commitment, and use of involuntary commitment process to facilitate a patient's access to psychiatric treatment.

Best Practices for Acute Behavioral Health Patients in the Emergency Department

Individual in behavioral health crisis presenting to the ED

Intake, Medical Evaluation + Triage 	Initial Behavioral Health Consult 	De-Escalation + Stabilization 	Observation + Ongoing Re-assessment 	Disposition 	Discharge: Return to Home + Community 
<ol style="list-style-type: none"> 1. Standardized assessment tool to quickly identify BH patients 2. Standardized medical clearance 3. Access from other care settings to patient's history, care plans + medication orders 	<ol style="list-style-type: none"> 1. Initial behavioral health assessment performed by a licensed behavioral health clinician to identify initial plan of action 2. Timely access to psychiatric evaluation, within facility or using telehealth, if indicated in clinician assessment. 	<ol style="list-style-type: none"> 1. Verbal de-escalation 2. Limited use of seclusion and restraints 3. Standing orders for stabilizing psychiatric medications 4. Initiate ex parte order, if needed 	<ol style="list-style-type: none"> 1. Dedicated area(s) for BH patients 2. Enhanced monitoring and security 3. Rescind ex parte order, when possible 4. Discharge to home safely, when possible 	<ol style="list-style-type: none"> 1. Admit to inpatient unit for short-term treatment, if needed 2. Develop care plan with patient, family, care coordinators, public guardians + other provider(s) 	<ol style="list-style-type: none"> 1. Nurse follow-up by phone after safe discharge 2. Arrange next-day appointment with community behavioral health or primary care provider 3. Refer to Coordinated Entry for people at risk of homelessness 4. Assess for home and community-based waiver services + connect to providers
5 Keys to Transforming Care for Behavioral Health Patients in the ED		<ol style="list-style-type: none"> 1. Trauma informed policies and protocols for working with behavioral health patients 2. Staff training and education, including security personnel 3. Strong integrated care team, including security personnel 4. Regular access to psychiatric consult, onsite or through telehealth 5. Case management across transitions in care and post-discharge 			

Project Goals

Project goals are rooted in the Institute for Healthcare Improvement (IHI) Innovation Project’s Theory of Change. Through discussion with ASHNHA staff and stakeholders, four goals for the ASHNHA Behavioral Health Improvement Project were identified:

1. Improve patient outcomes and experience of care within the ED and inpatient care settings for patients presenting with behavioral health conditions.
2. Improve staff safety within ED and inpatient care settings.
3. Decrease avoidable ED visits for individuals with behavioral health issues who present to the ED.
4. Decrease avoidable ED re-visits for individuals with behavioral health conditions who present to the ED.

Throughout the stakeholder meetings, providers reiterated that meeting these goals requires improvement and investment across the continuum of care, in addition to improvements within EDs. Without appropriate discharge options for patients with differing levels of acuity, hospitals will continue to struggle with ED visits and re-visits for individuals with behavioral health conditions.

Work Plan

The initial work plan is organized by setting and takes in to account interventions across the continuum. Through prioritization activities with the workgroup, the list of possible strategies was narrowed to 23 strategies in five settings. An overview of prioritized strategies by setting is provided here, with details on the top strategy in each section.

The table below identifies the components of the complete matrix of work plan strategies. Strategies are organized by setting. For each strategy, the roles of ASHNHA and individual hospitals are identified as well as an expected timeline, identified funding and resource needs and measures of success. Refinement and development of the work plan is on-going and thus a copy of the initial work plan matrix is not available in this report. ASHNHA staff, the behavioral health workgroup, and member hospitals will continue to update the work plan and use it as a guide for implementation planning and deployment of developed recommendations.

Strategy	ASHNHA’s Role	Hospital’s Role	Timeline	Funding/Resource Needed	Success Measure(s)
Setting A: Emergency Department					
Setting B: Hospital Inpatient					
Setting C: Alaska Psychiatric Institute					
Setting D: Home and Community Based Behavioral Health Services					
Setting E: Across the Behavioral Health Continuum					

Emergency Departments

Strengthening Alaska’s continuum of acute behavioral health services within emergency departments involves investment in emergency department’s abilities to provide behavioral health crisis intervention, management and evaluation. Strategies that rose to the top for emergency departments (EDs) involve facility, process, intervention and staffing changes the increase ED capacity to effectively and appropriately respond to behavioral health patients. Health Facilities Data Reporting (HFDR) data

analysis revealed that patients with delusional disorders and other nonorganic psychoses tend to be the population waiting the longest for safe transfer or discharge; this same group makes up a small percentage (less than one percent in 2017) of total behavioral health patients. The effect this small group of individuals has on ED boarding times is profound and should be a focus for ED-level intervention.

Throughout the workgroup convenings, stakeholders expressed interest in learning from one another and sharing best practices and lessons learned. ASHNHA's role in this work involves identifying and summarizing best practices, coordinating training for member hospitals and funding advocacy. Hospitals are charged with implementation of strategies in this setting.

The stakeholder group identified “**improve the process for post-discharge follow-up**” as their top priority for EDs. There is an evidence base that suggests that follow-up post cards and phone calls can be beneficial for some behavioral health patients discharging from the emergency department. Stakeholders voiced strong support for improving the post-discharge follow-up process in their facilities. Possible follow-ups range from simple phone calls or postcards with emergency telephone numbers and safety measures to more personal letters of support or post-discharge case management.¹⁶ Costs could be shared amongst hospitals by using a shared call center or case management organization.

Next Steps: Research different evidence-based models for providing post-discharge follow-up, including resources needed and costs. Present models to stakeholder group and select a model for further research and possible implementation.

Hospital Inpatient Units

Strengthening Alaska's continuum of acute behavioral health services in the hospital inpatient setting is largely focused on increasing the capacity of hospitals to provide stabilization and short-term treatment for behavioral health patients. Hospitals are interested in providing stabilization and short-term treatment (less than 30 days) for behavioral health patients, but in order to plan service lines and start viable programs stable and reliable reimbursement methodology is needed. To be successful in implementing short-term treatment, hospitals also prioritized the development of a statewide triage system for transfers of civil involuntary commitments to API, the need for case manager staffing to facilitate discharge planning and evaluation and advocacy work to potential revise the Mental Health Treatment Assistance Program. ASHNHA's work in this setting is primarily as an advocate, while the role of hospitals will primarily be implementation.

PEER SUPPORT TO TREAT ADDICTION

The Delaware START – 100 Million Healthier Lives initiative is focused on improving ED care for individuals with opioid and alcohol use disorders. Peer support is available 24/7 and when the patient is discharged a peer follows up within 24 hours. There is continued peer follow up until the patient enters treatment or connects with other needed supports.

¹⁶ Richardson, J.S., Mark, T. L., McKeon, R. *The Return on Investment of Postdischarge Follow-Up Calls for Suicidal Ideation or Deliberate Self-Harm*. Psychiatric Services in Advance; 2014.

The stakeholder group chose **“identify a reliable Medicaid reimbursement methodology for hospitals to increase inpatient capacity for short-term psychiatric treatment”** as its number one priority for the inpatient setting. Adding inpatient behavioral health capacity at regional hospitals is in-line with Alaska Statute 47.30.760 which identifies “if space is available and upon acceptance by another treatment facility, a respondent who is committed by the court shall be placed by the department at the designated treatment facility closest to the respondent’s home”, except in specific circumstances outlined in statute. Short-term treatment closer to home encourages connections between patients and their existing support networks and frees up treatment beds at API for patients who do not have access to regional inpatient behavioral health services and those who require longer-term commitments.

Next Steps: Develop talking points and information packets to educate policymakers about the stakeholder group’s work, what hospitals are willing to do and what is needed from the State of Alaska to address policy and reimbursement issues.

Alaska Psychiatric Institute

The Alaska Psychiatric Institute’s (API) average length of stay is well below the national average for similar facilities and 30 and 180-day recidivism is high. Short lengths of stay at API effectively leaves Alaska without a long-term, inpatient placement for behavioral health patients. In the complete continuum, API provides some stabilization and short-term treatment, but with regional hospitals serving more of this population, API is freed up to focus primarily on individuals requiring long-term treatment.

Stakeholders identified **“advocate for API to provide both acute and longer-term treatment in a safe and secure setting”** as the top priority for the workgroup in this setting. The 1115 Waiver Application identifies the transition of API back to its intended role as a long-term treatment facility for the most complex behavioral health patients as a goal of the demonstration project.¹⁷

Next Steps: Develop talking points and information packets to educate legislators about the work of the Acute Behavioral Health stakeholder group, what hospitals are willing to do and what is needed from the State of Alaska to address gaps in the continuum of care.

Home and Community Based Settings

Home and community-based settings provide invaluable resources to behavioral health patients through ongoing support and maintenance of conditions. Individuals with behavioral health needs require ongoing maintenance and support in the management of their conditions, just as medical patients with conditions like diabetes or heart disease do. Ongoing supports can be offered in a variety of settings, including outpatient therapy, permanent supportive housing, group homes, recovery support, intensive case management and assertive community treatment. Changes to processes such as

EXPANDING CAPACITY
Mat-Su Regional Medical Center and Alaska Regional Hospital received approved certificates of need for the addition of behavioral health beds to their facilities in 2017.

¹⁷ State of Alaska Department of Health and Social Services. *Medicaid Section 1115 Behavioral Health Demonstration Application*, 2018.

creating a mechanism for next-day behavioral health appointments for patients discharged from the ED, behavioral health high utilizer programs, the integration of behavioral health and primary care and allowing additional provider types to bill Medicaid all expand capacity for home and community-based programs to provide services to individuals with behavioral health needs. Serving more people at lower levels of care is more cost-effective than serving these individuals in acute settings.

Stakeholders prioritized **“secure agreements for next-day behavioral health follow-up appointments post-ED”** as a crucial next step in improving the discharge process and connecting behavioral health patients rapidly with appropriate ongoing supports.

Next Steps: Communicate with local behavioral health providers to identify what resources are needed to support holding appointments for patients discharging from emergency departments. Identify the expected volume for each provider and/or region. Identify a funding mechanism for outpatient providers that incentivizes them to hold slots for this patient population.

Across the Behavioral Health Continuum

Strengthening Alaska’s continuum of behavioral health services relies on improving communication and access to resources across the continuum as well as evaluating statutes that impact individuals who need the highest level of care. At the February meeting, stakeholders identified an additional priority strategy for this area, in light of recent proposed reductions to Medicaid.

Stakeholders identified **“develop a shared tele-psychiatry contract among hospitals for psychiatric consults in ED and inpatient units and remove barriers to licensing for providers”** as their top priority. One ED physician shared that if he just had access to a psychiatric consult, he would likely be able to discharge patients much faster. Stakeholders identified that licensing, particularly for out of state providers, is a barrier that needs to be addressed in order to improve access to telepsychiatry resources.

Next Steps: Identify specific licensing barriers and solutions and advocate for change. Identify hospitals interested in participating in a shared tele-psychiatry contract and explore potential vendors to provide this contract.

MAINTAIN ALASKA’S INVESTMENT IN MEDICAID

Stakeholders recognize a great risk to services across the continuum if Alaska’s Medicaid budget is cut as proposed. Advocacy to protect Medicaid funds and Medicaid Expansion is an opportunity for community behavioral health providers, social services, long term care providers and hospitals to come together with a unified voice to present the benefits of Medicaid and Medicaid Expansion in Alaska to state legislators as they develop the budget for FY20.

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