ADDRESSING GAPS IN THE CRISIS PSYCHIATRIC RESPONSE SYSTEM

JANUARY 21, 2020 | CASE # 3AN-18-09814CI

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INTRODUCTION

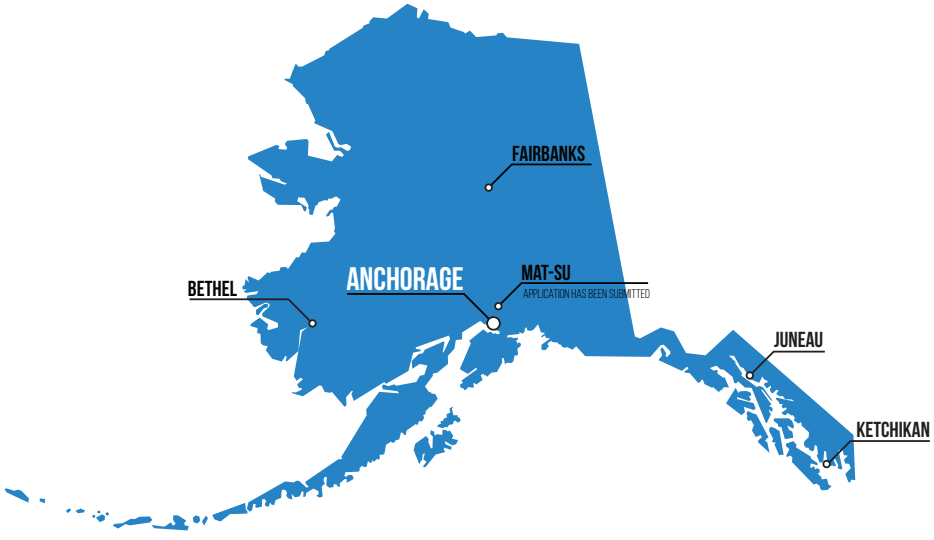
This report is submitted pursuant to the court order dated October 21, 2019, which was issued after a multiday evidentiary hearing. The court ordered the Department of Health and Social Services (DHSS) to submit a written plan explaining how it intends to address certain flaws in the Title 47 system in the Anchorage area.[1]

The order focused on places where the system has backed up: specifically, Department of Corrections (DOC) facilities and the emergency departments (ED). The Title 47 system of care is one part of the larger continuum of care related to behavioral health services in Alaska. To address these issues, we must more broadly address the systems of care if this plan is to be successful.

THE TITLE 47 SYSTEM OF CARE IS ONE PART OF THE LARGER CONTINUUM OF CARE RELATED TO BEHAVIORAL HEALTH SERVICES IN ALASKA. TO ADDRESS THESE ISSUES, WE MUST MORE BROADLY ADDRESS THE SYSTEMS OF CARE IF THIS PLAN IS TO BE SUCCESSFUL.

During the formulation of this response, DHSS has coordinated with numerous stakeholders involved in the behavioral health system, and has attempted to coordinate the response to this court order with many ongoing efforts around the state both within and outside of DHSS. DHSS is committed to the continued coordination of these efforts beyond this report, and to continue to meet the mission of DHSS to improve the health of Alaskans today and in the future. However, this report is focused on the Title 47 system of care in the Anchorage area.[2]

MAP OF DES/DET LOCATIONS IN ALASKA



1. DHSS reads the court's order as intending to focus on the problems presented in the hearing, which were problems in the Anchorage area. To the extent that the court wanted DHSS to consider statewide issues, please see footnote 2.

2. As noted below there is a statewide system of care for acute psychiatric care, which is funded by the State of Alaska, Department of Health of Social Services (DHSS). However, the provision of this care, outside of API, is done by facilities that are not owned or operated by the State of Alaska. Four facilities at this time provide emergency care in Alaska under the Designated Evaluation and Stabilization or Designated Evaluation and Treatment facility (DES/DET) programs. Currently there are two DES facilities in Alaska (Yukon-Kuskokwim Delta Regional Hospital and Ketchikan PeaceHealth Medical Center) and two DES/DET facilities (Fairbanks Memorial Hospital and Bartlett Regional Hospital). In November 2018, North Star Behavioral Health System was granted DET status, but is not currently accepting DET patients. The DET facilities are directly impacted as they provide both the evaluation and the treatment (similar to API). The DES facilities provide evaluation and stabilize for up to seven days. Individuals can only be committed to a DET and not a DES. To be clear, the evidence presented at the hearing focused on the Anchorage area and the problems in Anchorage and the Third Judicial District. DHSS' plan for the DET services provided in Fairbanks and Juneau at the request of those hospitals is that we "do not fix what is not broken" and to continue to support those DETs. DHSS acknowledges the requests of our partners in Fairbanks and Juneau. This plan focuses on the Anchorage bowl area and recognizes that fixing the psychiatric system of care in Anchorage is critical. However, many of the issues and concerns that were raised in litigation simply do not exist in those locations. DHSS recognizes that the DETs of Fairbanks Memorial Hospital and Bartlett Regional Hospital are a critical component of our system of care, and believes that implementing an "Anchorage-focused" solution is what is currently required.

As used in this document, "Title 47" refers to Alaska Statute Title 47, Article 9, "Involuntary Admission for Treatment."

THE CURRENT SYSTEM OF CARE

HISTORY

In 1956, the Mental Health Trust Enabling Act transferred responsibility for mental health services from the federal government to the territory of Alaska and ultimately the State of Alaska. In addition to some initial federal funds to support these services, one million acres were granted and selected from the public lands in the State of Alaska. These lands and the income and proceeds thereof were to be administered as a public trust and such proceeds and income were to be first applied to meet the necessary expenses of the mental health program in Alaska. The Legislature of Alaska was given a fiduciary responsibility to manage this public trust.

As noted by Dr. Jerry L. Schrader, former director of the Alaska Mental Health Program, before 1981, Alaska Psychiatric Institute (API) was the only designated psychiatric facility in the state, meaning it was the only facility in the state that could involuntarily hospitalize people for behavioral health evaluation and treatment.

It is possible for other hospitals to provide these services. However, hospitals must voluntarily apply for designation to evaluate respondents. In 1981, the Senate Health, Education, and Social Services Committee acknowledged the practical problems of getting facilities to perform evaluations by questioning what would happen when hospitals refused to take potentially psychotic patients. The committee did not resolve that question. From 1981 until very recently, only Fairbanks Memorial Hospital and Bartlett Regional Hospital became designated facilities.

In 1981, Alaska adopted a decentralized system of behavioral health care in a major revision of the civil commitment statutes. The rationale behind this approach was that in-community services would be developed which would reduce the need for institutional care.

In practice, however, Alaska never developed a strong system of behavioral health community services.[3] Unfortunately, the number of Alaskans needing mental health services has risen, while recruiting and retaining mental health providers and substance abuse providers has only become more difficult. These problems have resulted in increasing pressure on API, the court system, DOC, public safety, and hospitals, including emergency departments.

The physical and functional capacity of API itself was reduced over the years. In 1962, API was built with 225 beds, when Alaska's population was much lower than it is now. In 1992, a study indicated that 162 beds were needed. A meeting in 1992 called the "Alyeska Accord" with 42 statewide mental health advocates and stakeholders resulted in a plan for 114 beds, with additional outpatient services. Following legislative funding decisions and

3. In fact, by 1982, a class action suit was filed due to the lack of behavioral health services within the state. The outcome of this case resulted in restoration of the original trust and reconstruction of its assets. Compare State v. Weiss, 706 P.2d 681 (Alaska 1985).

THE CURRENT SYSTEM OF CARE (CONT.)

DHSS' search for non-general fund money, in 2005, the new API building opened with only 80 beds.

Because Alaska never developed a strong system of behavioral health community services, the DES/DET beds have been the primary means of treatment for those with acute psychiatric needs.

CURRENT STATUS

Both Fairbanks Memorial Hospital and Bartlett Regional Hospital in Juneau have been designated evaluation and treatment (DET) facilities for years, with both accepting voluntary and involuntary patients. Mat-Su Regional Hospital will start operating a new psychiatric unit in January 2020, and submitted their DET application to the Division of Behavioral Health on January 14, 2020. DHSS anticipates that DET designation will be granted after official review is complete. Fairbanks Memorial Hospital operates 20 beds, Bartlett Regional Hospital operates 12 beds, and Mat-Su Regional Hospital will operate 16 beds when at full capacity.

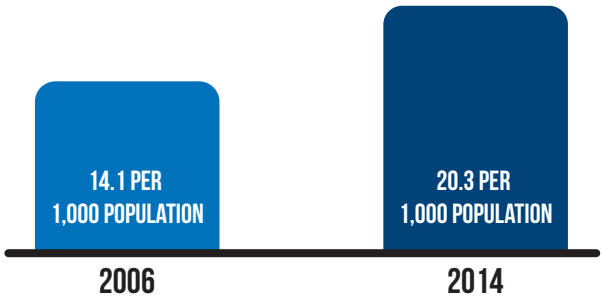
Over the last several years, there have been attempts to address staffing shortages at API through legislative appropriations for psychiatric nurses and other specialized positions. Unfortunately, API has still struggled to fill these funded positions due in part to the state hiring system. Despite the unique needs of API, including its requirements to adhere to strict regulatory standards by multiple oversight agencies, it is subject to the collective bargaining agreements (CBA) governing statewide administrative employees. The current statewide CBAs are dissimilar to the expectations of hospital regulators.

Nationally, over the last several years, there has been a large rise in patients presenting with behavioral health challenges. A 2017 Centers for Disease Control and Prevention (CDC) report estimated a 44% increase in the rate of mental health and substance abuse-related ED visits from 2006 to 2014 with suicidal ideation growing the most (415%).

For a detailed analysis of these statistics please see:

https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf.

RATE OF EMERGENCY DEPT. VISITS FOR MENTAL HEALTH AND SUBSTANCE ABUSE



Nationally and statewide, this rise in patients presenting in crisis has only been exacerbated by a shortage of behavioral health providers. There simply are not enough providers to meet these needs, including medication prescription and management and all types of talk-based therapy. This has made staffing and care models a challenge in the outpatient setting, in hospitals, and emergency departments, as well as inpatient facilities such as API and other DET facilities.

Given the increase in cases and the lack of a full continuum of care for behavioral health emergencies in the state, many components of this system are continually stretched beyond capacity, especially in Anchorage.

GIVEN THE INCREASE IN CASES AND THE LACK OF A FULL CONTINUUM OF CARE FOR BEHAVIORAL HEALTH EMERGENCIES IN THE STATE, MANY COMPONENTS OF THIS SYSTEM ARE CONTINUALLY STRETCHED BEYOND CAPACITY, ESPECIALLY IN ANCHORAGE.

EXISTING EFFORTS

DHSS and its partners have been engaged for several years in the planning and development of solutions for the complex challenges (and gaps) in the Alaska system of care. Some of these are highlighted below, and range from API-specific to preventative and systemic changes.

EFFORTS TO STUDY THE PROBLEMS

In recent years, both the state and other advocates have been focused on finding solutions to these challenges. These advocates include DHSS, local communities, hospitals, tribes, the Alaska Mental Health Trust Authority (the Trust), DOC and others. The support of the Alaska Mental Health Trust Authority has been essential to many of these efforts.

In 2018, the Alaska State Hospital and Nursing Home Association (ASHNHA) requested funding from the Trust to form a working group to convene stakeholders with the intention of developing statewide solutions to gaps and delays in the continuum of care for behavioral health. The Trust provided funding of $95,000 that led to creation of the ASHNHA Acute Behavioral Health Improvement Project, which issued a final report in April 2019.[4] DHSS was a participant in this working group. One of the recommendations from this report was to establish a crisis stabilization center apart from emergency departments.

For the past several years, DHSS has been exploring the possibility of establishing crisis stabilization services. In December of 2017, DHSS organized a site visit to New Jersey to look at mobile crisis teams, and brought other advocates including the Trust and community providers. In August 2018, then-director of the Division of Behavioral Health, Randall Burns, gave a presentation to the Trust board of trustees that included emphasis on crisis stabilization and focus on psychiatric care.

In September 2018, DHSS issued a request for proposals (RFP) for Substance Use Disorder Services Expansion, including crisis stabilization. Bartlett Regional Hospital proposed a new crisis stabilization center, which was funded by DHSS and additionally funded by the Trust. The hospital is currently working with DHSS and the Trust to stand up the new center.

The Trust has continued coordination of crisis stabilization efforts, investing considerable resources in pursuing appropriate and timely solutions. It issued an RFP on July 25, 2019 for a contractor to provide consultation, assessment, analysis, and recommendations to support the conceptualization of a Crisis Now Model in Alaska. This contract was executed August 8, 2019, and the final report was issued on December 27, 2019.[5]

4. Available at ***https://www.ashnha.com/wp-content/uploads/2019/05/ASHNHA-Acute-Behavioral-Health-Project-Report_FINAL-with-Full-2018-Data5-03-19.pdf***

5. Available at ***https://alaskamentalhealthtrust.org/wp-content/uploads/2019/08/HandOut-RI-Crisis-Now-Alaska-Consultation-Report-12.27.19.pdf.***

EXISTING EFFORTS (CONT.)

DHSS has been fully engaged with this project, as well as continuing to receive support from others, such as the Milbank Foundation, to receive technical assistance and training on crisis stabilization. Staff from DHSS attended a two-day meeting in Arizona December 17-18, 2019 with members of the Trust, tribes, law enforcement, hospitals, behavioral health community providers, and other funders to see how this model could be used to address the behavioral health crisis system of care.

The Crisis Now Model, if implemented as designed, would become a part of a more robust system of care in Alaska.

CURRENT NON-API, NON-DET RESOURCES

THE CARELINE CRISIS CALL CENTER

Alaska has a 24/7 crisis call center, Careline, which is located in Fairbanks but accessible to all Alaskans. However, Careline must be strengthened to be a true statewide system.

There are currently a number of separate systems of communication that are used in managing the psychiatric system of care in Alaska. They currently include: the Alaska State Troopers central call line, a DHSS contract with OpenBeds for bed availability, 2-1-1, the State Health Information Exchange (HIE), and the Emergency Department Information Exchange known as the "EDIE" system run through Collective Medical. Alaska is seeking to improve, coordinate, and enhance crisis call services, by establishing a contract for an Administrative Services Organization (ASO) to coordinate these efforts.

1115 MEDICAID WAIVER - SUBSTANCE ABUSE SERVICES

The state has committed to a long-term plan to tailor Medicaid in Alaska to meet the unique challenges in this state (including all aspects of behavioral health). The 1115 Waiver demonstration project provides reimbursement to Medicaid providers that incentivize Alaska's behavioral health providers to deliver new services designed to create a full continuum of care, in which individuals in need of varying levels of treatment may step up or step down to the appropriate level of care.

This effort officially moved forward in July 2017, when Alaska submitted its concept paper to the Centers for Medicare and Medicaid Services (CMS). The application process for the 1115 Waiver was a multiyear commitment, which is now in the implementation stage.

In 2018, CMS approved Alaska's Section 1115 demonstration project titled Substance Use Disorder Treatment and Alaska Behavioral Health Program, authorizing the state to implement additional services to enhance the comprehensive services available under the behavioral health system for children, youth, and adults with, or at risk of, serious mental illness, severe emotional disturbance, and/or substance use disorders. In July 2019, emergency regulations were released as the mechanism to activate funding for the substance use disorder (SUD) component. This includes reimbursement for 12 new Medicaid services to treat SUD. This means that SUD services made available under the 1115 Waiver may now be billed through the Alaska Medicaid program, and will be able to assist our community behavioral health providers to address the gap services across the state, because the population that experiences SUD that have been identified as high users of emergency rooms. "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, and nondependent abuse of drugs." (Alaska State Hospital and Nursing Home Association - April 2019.[6])

EXISTING EFFORTS (CONT.)

1115 MEDICAID WAIVER – NEW BEHAVIORAL HEALTH SERVICES

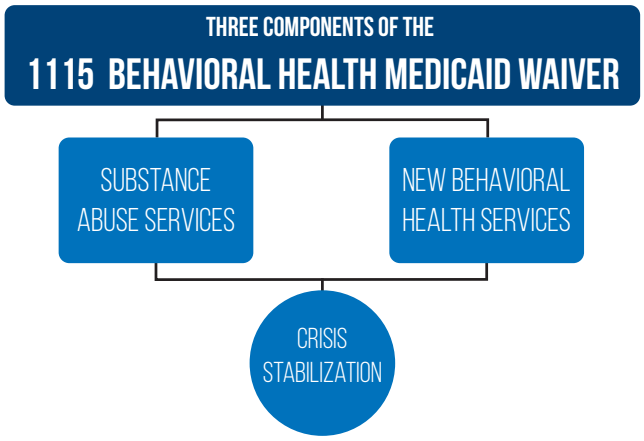
Effective September 2019, the Division of Behavioral Health (DBH) received approval from CMS for the behavioral health component of the 1115 Waiver. The division is in the process of developing draft behavioral health regulations, which will be effective in the winter of 2020. With these new services, DBH is implementing 23 reimbursable services to treat persons suffering from SUD and behavioral health disorders. By offering payment to providers for these services, DHSS anticipates demonstrable relief on the acute end of care, such as hospitals and API, by providing community-based treatment options that prevent psychiatric emergencies in the first place. This will relieve unnecessary pressure on API.

The 1115 Waiver targets populations with mental disorders that would include clinical admission criteria as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

1115 MEDICAID WAIVER - CRISIS STABILIZATION

The 1115 Waiver also enables payment for service providers of critical elements of a crisis safety net system for individuals in acute mental health crisis. This will include 23-hour observation and stabilization centers, as well as short-term residential crisis stabilization programs, and mobile crisis mental health stabilization teams that work with people in the community to prevent the crisis from escalating.

These new services are intended to provide appropriate clinical interventions, in appropriate settings, by qualified mental health professionals and to connect individuals to the appropriate level of care and services within the community. Expanding services to include 23-hour and short-term crisis stabilization will reduce the reliance on hospital emergency departments and law enforcement as primary responders by establishing new programs designed specifically to respond to and stabilize mental health crises. These new program types will enhance the continuum of behavioral health intervention beyond what currently exists, which is limited to inpatient (institutional) and general mental health outpatient care.



*6. Available at **www.ashnha.com/wp-content/uploads/2019/05/ASHNHA-Acute-Behavioral-Health-Project-Report_FINAL-with-Full-2018-Data5-03-19.pdf***

It is important to note that current data shows that bed capacity for mental health services can be impacted and, is impacted by persons suffering from substance use disorders. As the 1115 SUD programs and services come online we expect that there will be reduction of psychiatric beds being used by SUD recipients because those individuals, who are also in crisis, will receive services from SUD providers.

EXISTING EFFORTS (CONT.)

API

DHSS recognizes that the issues at API, while not solely responsible for the delay in psychiatric evaluations in the Anchorage area, are an important factor. There is no way to talk about solutions without mentioning the need for getting API back to full capacity as a fully functioning psychiatric hospital.

DHSS has been working diligently on a variety of mechanisms to get API back to full capacity. Those factors include, but are not limited to:

1. The contract with Wellpath Recovery Solutions has been in place since February 8, 2019. This contract currently extends to March 31, 2020, and has provided much needed stability in major components of the facility, including support for administrative and clinical work.[7]
2. Since November 2017, API has worked through at least 18 plans of correction based upon reviews of the facility by CMS and other accrediting or oversight agencies. CMS has periodically placed API under program termination dates due to "deficiencies [which] limit the capacity of the Alaska Psychiatric Institute to furnish services of an adequate level and quality." Multiple reviews put API at the precipice of losing their certification with the Medicaid program, which would have been catastrophic.[8] The consistent and diligent focus on coming into compliance with regulatory requirements in order to keep API open has led to improvements in the day-to-day operations of the facility. As of December 27, 2019, CMS (1) rescinded its termination action; (2) reinstated API's "deemed" status through The Joint Commission, and (3) removed the hospital from state survey agency jurisdiction. In other words, API is now considered compliant and able to operate under state and federal rules.[9]
3. While much of the clinical staffing is more stable, we continue to struggle with staffing some clinical positions, maintaining enough psychiatric nurse assistants (PNA), and other shift staff to open more beds. In particular, it is difficult to achieve minimum staffing requirements on weekends, which dictates the number of patients that can be served during the week.
4. Over the last two years, DHSS has solicited multiple contracts to analyze the overall functionality and future of API. Those two contracts relate to the two types of services provided by API: civil commitment and forensic evaluation and restoration.

7. Available at: ***http://alaska.gov/go/J0S3***

8. In a May 2018 survey, the surveyors found that a patient had been sexually assaulted by another patient and API staff had not properly responded to or reported this incident. In a January 2019 survey, the surveyors issued an "Immediate Jeopardy" finding, the most serious type of violation, based on unwanted sexual contact perpetrated on a patient that the facility did not properly respond to. ("Immediate Jeopardy" means the facility placed the health and safety of patients at risk for serious injury, harm, impairment, or death.)

Again, in an April 8, 2019 survey, the surveyors issued an "Immediate Jeopardy" finding, this time for improper restraints which placed the patient in immediate jeopardy for serious harm and/or death while restrained.

Detailed information can be found at: ***http://alaska.gov/go/2AXK***

9. We caution the court, however, that API's "deemed" status is in no way guaranteed. API achieved "deemed" status in Fall 2019, only to have it revoked three weeks later. Consistent and diligent work remains essential.

EXISTING EFFORTS (CONT.)

- API is a critical component of the Title 12 evaluation and restoration process for criminal defendants. In 2018, DHSS contracted for a forensic study to evaluate how to better serve this population without negatively impacting the level of care for civil patients at API.[10]
- In November 2019, DHSS entered into a contract with Western Interstate Commission on Higher Education (WICHE) to conduct a full analysis of potential operational models for API, including but not limited to status quo, privatization, or becoming a state public corporation. This analysis is due January 31, 2020, and is to consider qualitative and quantitative metrics including costs and quality of patient care.[11]

DES/DET SYSTEM OF CARE

As noted above, the current system of psychiatric care relies upon the DES/DET system. We currently have four non-state-owned participating providers in this system. The two non-state-owned DET facilities are Fairbanks Memorial Hospital and Bartlett Regional Hospital. The two DES facilities are Yukon-Kuskokwim Delta Regional Hospital and PeaceHealth Ketchikan Medical Center. Each of these facilities are critical to the overall functionality of the acute psychiatric system of care in Alaska. Additionally, Mat-Su Regional Medical Center is planning to open a 16-bed psychiatric unit in January 2020, and is expected to become another DES/DET provider.

This system of care is critical to success, but more concrete and focused effort needs to be made to ensure its continued viability. This includes working together on system improvements, looking at the funding of these services both in terms of inpatient bed days and in terms of the administrative costs it takes to operate these programs.

Additionally, the state has recognized that psychiatric care cannot solely rest upon acute crisis management within DET facilities under the involuntary commitment process. Because of this, various state agencies have been researching and planning for enhancements to psychiatric service components within the state.

10. Available at: ***http://alaska.gov/go/2AXK***

11. Available at: ***http://alaska.gov/go/R75R***

TRACKING OF EX PARTE RESPONDENTS WAITING FOR ADMISSION TO API OR DET

The civil commitment process begins with a patient in crisis. Usually, the patient ends up in a health care facility or, in some locations, emergency departments, while awaiting evaluation and treatment.[12] DES/DET facilities and API used to take patients from the community without an *ex parte* order, but with the increasing wait times, often the emergency departments or DOC are the only 24/7 facilities that can hold patients awaiting transfer. If the treating providers find the patient is an acute threat to themselves, others, or is gravely disabled, they will file a petition for an *ex parte* order to hospitalize with the local court. The case is reviewed and if the judge or magistrate judge finds that there is probable cause, the respondent is mentally ill and either likely to cause harm or unable to care for themselves, then the *ex parte* order to hospitalize is granted. By statute, respondents are to be notified that they are being detained under an *ex parte* order; however, unless that happens at API, DHSS has no way to real-time track whether facilities are providing this notification as required.[12] Those notices are filed by the facility with the court. As the system has become overwhelmed, the respondents often wait for admission to API or another DET. Those individuals wait in referring hospitals across the state, or in some instances in a Department of Corrections facility. The Anchorage use of the DOC for psychiatric holds was higher during a period of time in 2018/2019; it is not a consistent issue in other districts.[14]

ALTHOUGH THE SAME STATUTORY SCHEME APPLIES TO ALL, EACH DET FACILITY MANAGES THEIR PSYCHIATRIC CARE TO MEET THE NEEDS OF THEIR COMMUNITIES AND LOCAL COURT SYSTEM.

Each judicial district handles *ex parte* orders differently. Although the same statutory scheme applies to all, each DET facility manages their psychiatric care to meet the needs of their communities and local court system. The success of these DET providers should not be undermined by imposing changes to their system of care through this plan. Rather, the plan should ensure that the DET providers are supported as a critical component to the larger system of care.

12. Although the emergency room and the psychiatric ward of Fairbanks Memorial Hospital are in the same building, clinically appropriate evaluations at FMH can only be done at the psychiatric ward, not the emergency room.

13. For DHSS to address the status, location, and expected arrival of ex parte respondents to API or a DET, DHSS must be able to identify each of these individuals. DHSS' ability to identify those subjects to an ex parte evaluation order is dependent upon the actions of non-DHSS parties – specifically, referring hospitals, community providers, or police/troopers who are seeking court orders for evaluation. DHSS can only become aware of individuals subject to an order once the court and/or parties transmit that information, at which time Gabriel C. requirements begin. Factors outside of DHSS control may delay such notification, such as technology failure in rural areas; the court system's choice not to fax orders; and the fact that some courts often send orders to API 24-28 hours after an order is signed.

In re Gabriel C., 324 P.3d 835 (Alaska 2014).

14. This is not an issue in Fairbanks, as the judicial officers will not issue an order to allow an ex parte to be held at a DOC facility or local jail; this does happen in Juneau on rare occasion and usually happens if weather or other transportation issues occur when a person is ex parte'd in rural Southeast Alaska.

TRACKING OF EX PARTE RESPONDENTS WAITING FOR ADMISSION TO API OR DET (CONT.)

Due to the lack of a consistent approach, tracking the location of a person subject to an *ex parte* order and who is supposed to be immediately transported to API or a DET facility has fallen squarely upon the Department of Law. In 2012, the court amended its *ex parte* order to require the Department of Law to track and monitor all *ex parte* orders by filing a status report with the court issuing the *ex parte* order every 24 hours while a respondent is awaiting transport to a DET. This is being handled by the three Attorney General's offices that track orders within their jurisdiction as follows:

FIRST JUDICIAL DISTRICT

The Juneau Attorney General's Office receives copies of most of, but not all *ex parte* orders, and only after the respondent arrives at Ketchikan PeaceHealth Medical Center or Bartlett Regional Hospital (BRH). The court often indicates that only Ketchikan PeaceHealth Medical Center or Bartlett Regional Hospital may be considered, and if so, those orders are sent only to the Juneau Attorney General's Office. A paralegal or assistant attorney general there works on the status reports and files them each day that a respondent has not been transported to API or the DET.

SECOND JUDICIAL DISTRICT

These *ex parte* orders are tracked sometimes by the Anchorage Attorney General's Office and sometimes by the Fairbanks office, because the court system is not consistent about indicating if only Fairbanks is to be considered or if all three evaluation facilities are to be considered.

THIRD JUDICIAL DISTRICT AND BETHEL

The Anchorage Attorney General's Office receives copies of all the *ex parte* orders, because those courts always indicate API should be one of the possible evaluation facilities. A paralegal there tracks every order, and their outcomes, in multiple spreadsheets.

FOURTH JUDICIAL DISTRICT

The Fairbanks Attorney General's Office receives copies of the *ex parte* orders. The Fairbanks court usually indicates that only Fairbanks Memorial Hospital (FMH) may be considered. The court system will send Fairbanks-only orders only to the Fairbanks Attorney General's Office. A paralegal there works on the status reports.

90-DAY PLAN

HIRE STATEWIDE DES/DET COORDINATOR

DHSS will create and hire a new position which will be placed within the Commissioner's Office. Through this statewide DES/DET coordinator, we hope to improve patient care and reduce administrative burdens on emergency departments, DOC, and DET facilities including API as well as the Department of Law. This will be a change in practice and through a coordinated, patient-centered approach at DHSS we hope to leverage all available resources to serve this patient population.

THROUGH THIS STATEWIDE DES/DET COORDINATOR, WE HOPE TO IMPROVE PATIENT CARE AND REDUCE ADMINISTRATIVE BURDENS ON EMERGENCY DEPARTMENTS, DOC, AND DET FACILITIES INCLUDING API AS WELL AS THE DEPARTMENT OF LAW.

This position is designed to:

1. Ease the administrative burden on hospitals and the Department of Law to manage orders issued by courts;
2. Track available beds (API and DET facilities), keep a waitlist for admission and facilitate transportation of respondents. This will allow DHSS to assume much of the administrative burden by allowing DET facilities and emergency departments to focus on direct patient care.
3. Provide a mechanism for DHSS to be aware of and track the burden of behavioral health emergencies in the state, the number of *ex parte* respondents and the length of stay to inform systems change and programmatic work moving forward.
4. Assist in facilitating return to a person's home community if they are evaluated or treated in a different location.

Details on plans for this position include:

1. Responsibilities will be staffed using current resources, but DHSS will seek to staff or hire a full-time position within 90 days.[15]
2. Will be housed within the Commissioner's Office and shall report to the deputy commissioner who has responsibility over API.
3. Responsibilities will include serving as a single point of contact for the following:
   a. Receiving any documentation related to management of Title 47 from hospitals or DOC.
   b. Receive all Title 47 *ex parte* orders from all four judicial districts;

15. While it is expected that the position will be hired or filled within 90 days, it is important to note that the full operation of the DES/DET coordinator will be ongoing in terms of training and developing the communication and relationships with the referring hospitals, DET and DES facilities, and the court system.

90-DAY PLAN (CONT.)

c. Track all Title 47 *ex parte* orders to ensure completeness as well as patient movement and when *ex parte* petitions have been dismissed, revoked or vacated;
d. Receive and track daily updates on patient status and condition;
e. Provide information to referring hospitals and DOC on DET bed availability, wait times, and transportation;
f. Track and communicate other needed information for a patient transfer including successful medical screening and transfer information;
g. Coordinate between API, DET facilities (Bartlett Regional Hospital and Fairbanks Memorial Hospital), and DES (Ketchikan PeaceHealth Medical Center), and other providers to facilitate placement of those awaiting transport. NOTE: The DES/DET coordinator will not determine placement, but simply facilitate coordination between providers based upon clinical considerations;
h. Connect providers with psychiatric consultation (once established and available);
i. Coordinate as needed with other divisions within DHSS that could assist with patient care, including but not limited to the Office of Children's Services (OCS), Division of Juvenile Justice (DJJ), or Adult Protective Services (APS) housed within the Division of Senior & Disability Services (SDS);
j. Coordinate mental health professional(s) visits to various locations statewide to re-evaluate respondents, if necessary;
k. Coordinate with the implementation of the Medicaid Section 1115 Waiver (1115 Waiver) demonstration project to assist in improving the crisis response system of care.

4. The DES/DET coordinator **will not** replace strong, local referral and coordination patterns in Fairbanks or Juneau, but will be used to augment current practices to provide more transparency to the crisis system as a whole.

SUGGESTED REVISIONS TO MC-305

In order to allow for the best outcomes under this new system, the Alaska Court System should update form MC-305 by removing the option to select only certain DET facilities. This change will allow the DES/DET coordinator to work with the DETs to place patients quickly at the most appropriate DET.

Current MC-305 language:
The Department of Health and Social Services or its designee or_____shall arrange for immediate delivery of the respondent to the following evaluation facility for examination and evaluation of the respondent's mental and physical condition:

- Alaska Psychiatric Institute
- PeaceHealth Ketchikan Medical Center
- Bartlett Regional Hospital
- Fairbanks Memorial Hospital
- Other

Proposed new MC-305 language:
The Department of Health and Social Services or its designee or_____shall arrange for immediate delivery of the respondent to the soonest available evaluation facility, considering the respondent's clinical needs.

90-DAY PLAN (CONT.)

CREATE PROCEDURES TO ENABLE OFFSITE EVALUATIONS OF PERSONS WAITING FOR BEDS AT A DES/DET

The court's order requires DHSS to formulate a mechanism to re-evaluate respondents who are waiting admission to a DET.[16] This reflects the information presented in evidentiary hearings indicating that some respondents are held under an order without timely re-evaluation for criteria, resulting in unnecessary hospital costs as well as long stays for the respondent.[17]

DHSS WOULD LIKE TO CONTRACT WITH OR CREATE A PROVIDER AGREEMENT FOR A "MENTAL HEALTH PROFESSIONAL" (MHP) AS DEFINED IN AS 47.30.915(13) TO RE-EVALUATE ANY PERSON BEING HELD ON AN EX PARTE ORDER THAT IS WAITING FOR TRANSPORTATION TO API OR A DET.[18]

To address this, DHSS would like to contract with or create a Provider Agreement for a "mental health professional" (MHP) as defined in AS 47.30.915(13) to re-evaluate any person being held on an *ex parte* order that is waiting for transportation to API or a DET.[18]

The purposes of this position are to help non-DET facilities which may be limited in their ability to evaluate patients, or to help clarify whether an individual still meets criteria under AS 47.30 and needs to be held pending transport to API or a DET for further evaluation or treatment.[19]

This model is based upon DHSS' long-standing psychiatric emergency services (PES) grant, under which grant recipients already provide this type of service in communities across the state.[20] By having agreements with MHPs to provide statewide services, DHSS will standardize the system of re-evaluation.

Details on this contractor(s) include:

1. Within 90 days, DHSS will issue a Provider Agreement statewide for mental health professionals (MHP) to apply to be providers under this plan. These providers will be paid for by the state, and will be deployed to facilities when respondents are not being transported to API or a DES/DET for a psychiatric evaluation within 48 hours of admission to the referring facility;
2. The MHP will work as a clinical resource for the statewide DES/DET coordinator and the hospitals;

16. Morse Order page 59, point 4: "Identify procedures and mechanisms whereby a person, subject to an evaluation order, who is waiting to be admitted to an evaluation facility can be evaluated, outside of an evaluation facility, to determine if that person no longer meets evaluation criteria or could be transported to an alternate facility."

17. In DHSS' experience, there is evidence outside of the hearings in this case that suggests a re-evaluation could be helpful. For example, DHSS is aware of a patient who was ex parte'd by a referring hospital because of suicidal ideation. Upon review, however, it was learned that the patient had not expressed suicidal ideation in over a week.

18. However, in order for the MHP to perform this duty, each hospital must give the MHP permission to screen respondents remotely or at their facility. DHSS cannot require the hospitals to grant permission, or to process a request for permission within any given time. DHSS' best estimate is that the process would take at least three to six months for each individual location. Once the permission issues are resolved, the evaluations will take place in person and when clinically appropriate. A remote evaluation process can be used that may include the use of internet-based telemedicine companies such as Teledoc.

19. Based on clinical advice, the MHP will not file 30-day petitions, but will perform reviews of ex parte respondents. The MHP may or may not be a physician or psychiatrist. A mental health professional and a physician must sign a 30-day petition, but the legislative history indicates that the requirement of a physician was to make sure that a respondent was medically clear to travel to a DET. Therefore, having a "mental health professional" perform reviews is consistent with legislative intent.

20. See Appendix A for a statewide list of PES providers.

90-DAY PLAN (CONT.)

3. The MHP will provide additional mental health services and support to referring hospitals related to the clinical needs of the patient;
4. The MHP will be deployed to the referring facility if a respondent has not been transferred to a qualified DET within 48 hours of admission to the referring hospital;
5. Upon being deployed, the MHP will review the case with the referring hospital and potentially evaluate the patient;
6. If there is a discrepancy between the evaluation from the MHP and the referring hospital regarding the grounds for *ex parte*, either party may move the court for judicial review of the *ex parte* order.

Apart from arranging for re-evaluations by a qualified MHP, the other procedure to enable review of waiting *ex parte* respondents is judicial.

One option for judicial review would be to adopt the Fairbanks system of requiring a hospital to provide an update on the respondent's condition. Currently, the court system's form order requires DHSS – not the hospital with actual first-hand knowledge of the respondent – to file a status report. The Fairbanks court system was experiencing substantial conflict about respondents waiting for admission to Fairbanks Memorial Hospital's psychiatric ward. The conflict has been resolved by the emergency room filing a daily update on the respondent's condition. It is a narrative report, usually titled "Update on Respondent's Condition," submitted by a mental health professional, that provides a short update on the respondent's physical condition, the results of the last mental status examination, examples of the respondent's current behavior, present risk factors, and if the mental health professional believes that the respondent still meets criteria to be detained. If such reports were filed by those with first-hand knowledge of the respondent, the court system could review the reports and take any appropriate action. On DHSS' part, the court reports would be tracked by the DES/DET coordinator position.[21]

21. DHSS also believes that the court system should reinstate bench bar meetings regarding Title 47 and develop a court committee that includes referring hospitals and DES/DET facilities other than API. Lack of involvement by these parties contributes to confusion and inefficiencies. For example, in 2017, the Alaska Court System modified its MC 305 form so that it no longer expired after seven days, which in essence authorizes an indefinite hold. This would be an instance where stakeholder input prior to change would have been valuable to the system.

90-DAY PLAN (CONT.)

ORDER THE API WAITLIST BY PRIORITY RATHER THAN CHRONOLOGY

API is the only hospital under DHSS control and thus DHSS cannot dictate or clarify factors used in prioritization of admissions at Fairbanks Memorial Hospital or Bartlett Regional Hospital. Those facilities, or future DETs, should continue to use their best clinical judgment.

DHSS HAS BEEN AND CONTINUES TO BE FOCUSED ON STRENGTHENING THE CONTINUUM OF CARE, WHICH INCLUDES INCREASING THE BED AVAILABILITY AT API.

DHSS has been and continues to be focused on strengthening the continuum of care, which includes increasing the bed availability at API. However, DHSS recognizes that the way forward to address the Title 47 issues in the Anchorage area is much broader than simply staffing and increasing capacity at API. DHSS is not relying solely upon that "fix" to address the overall concerns about capacity in the Anchorage area. Even with full bed capacity at API, there may continue to be system pressures that result in a waitlist.

Considering these concerns, DHSS believes that there should be discussion on how patient admissions happen, including looking at priority lists, rather than relying solely upon admission based upon chronological factors. By looking at all of these factors, admissions will better reflect the needs of patient care across the continuum.

Currently, API uses a two-tier chronological admission system. Anyone in DOC custody or in the community is on the "community *ex parte* list." That list has priority. Other patients are accepted in chronological order when the community *ex parte* list has been cleared.

Under this 90-day plan, in coordination with our hospital partners, API would move to ordering admission based on clinical condition of the patient, taking into account variables such as:

- The length of time the patient has been waiting for psychiatric evaluation and/or treatment;
- The patient's past medical and psychiatric history;
- The patient's clinical course; and
- The location of the patient currently held and available local resources.

The "community *ex parte* list" will remain the top admission priority, with the above factors applied to admission decisions within that list.

Admission to API is handled, and will continue to be handled, by the API Admissions and Screening Officer. The Admissions and Screening Officer routinely receives records from referring hospitals or other referrers (rural communities or DOC), and routinely speaks with referrers. The Admission and Screening Team consists of social workers and a Licensed Independent Practitioner (LIP). As noted above, the statewide DES/DET coordinator will work closely with the admissions officials at all DES/DET facilities, including API to ensure statewide tracking of individuals waiting for DES/DET services.

Bartlett Regional Hospital, Fairbanks Memorial Hospital, and any future DET facilities will retain their autonomy to make admission decisions to their hospitals.

90-DAY PLAN (CONT.)

PAY PARTICULAR FOCUS TO THOSE RESPONDENTS AT DOC FACILITIES[22]

The population of *ex parte* respondent civil detainees in a DOC facility can be divided into two groups:

1. Persons subject to an evaluation order that DOC obtained while the person was in DOC custody;[23] and,
2. Persons subject to an evaluation order who were brought to DOC because an evaluation facility was unable to admit them and there were no criminal charges pending.

As to the first group, communication will be key to getting these individuals moved out of DOC custody as quickly as possible, but the DES/DET coordinator must be included in all decisions related to this matter. The DES/DET coordinator will commit to diligent efforts to work with DOC to assist with proactive planning for those that DOC identifies at entry as likely to need psychiatric care. DHSS, the Trust, and DOC met on December 20, 2019 to discuss better coordination and communication on individuals who are in DOC custody who are experiencing psychiatric issues. DHSS is committed to continuing these conversations.

There is no requirement for DOC to notify DHSS when a person is brought to DOC for a Title 47 admission. DHSS will make efforts to partner with DOC in creating a process of notification for Title 47 admissions.[23]

As to the second category, this is more problematic as many times these placements are done out of necessity. In remote rural areas, the jail may be the only place to hold a respondent, and weather may prevent any ability to leave the location for days at a time.

DHSS cannot prevent law enforcement from transporting individuals to DOC or to a non-clinical restrictive setting, particularly because in rural areas law enforcement often consists of Village Public Safety Officers (VPSO) and/or Village Police Officers (VPO) and local jails and holding facilities are not under the control of DOC. For the Third Judicial District, this situation has arisen in such remote communities as Saint Paul in the Pribilof Islands. As to these respondents, DHSS commits to improving communication between DHSS and DOC, so that these individuals are discovered as soon as possible so the DES/DET coordinator can facilitate further evaluation or transportation to API or a DET as soon as possible.

While it is DHSS' intention to limit jail stays as much as possible, it cannot guarantee that every person in protective custody can or will be released within 24 hours.

22. This is a problem specific to the Anchorage area. In the Fourth Judicial District, judges will not authorize ex parte orders for those in facilities operated by the Department of Corrections. In the First Judicial District, there are rare instances where a judge will authorize an ex parte order on someone who is in a rural area and there is no other safe holding place other than a jail or similarly restrictive facility.

23.The DOC requests an ex parte evaluation only after a person has entered DOC on criminal charges which are subsequently dismissed or resolved in a manner that would require immediate release to the community. DOC only requests ex parte evaluations for those individuals believed to be gravely disabled or who present a danger to themselves or others.

24. It is important to note that communication and coordination with rural jails will be much more complicated due to the number of entities we will need to work with and the fact that many rural jails do not have these issues or the issues are very rare. Despite this challenge, DHSS is evaluating how to use the DES/DET coordinator at a means to improving that communication.

90-DAY PLAN (CONT.)

Finally, the statutory language is that a respondent may only be held in a jail for "protective custody purposes," and this is an individualized determination for each respondent. Because clinical considerations are paramount, DHSS cannot create a blanket category of those ineligible for protective custody. However, we do agree the courts should be noticed immediately when a placement in a DOC facility or a local jail occurs.

The DES/DET coordinator will be available for DOC leadership, the Alaska State Troopers, and local law enforcement agencies should they choose to use that resource.

CREATE PROCEDURES TO ADDRESS RESPONDENT'S NOTIFICATION OF RIGHTS

By statute, an *ex parte* respondent is supposed to receive notice of their legal rights upon admission to API, a DES, or a DET. When a respondent is placed in a DES or DET, those providers are required to provide respondents this advisement under AS 47.30.725 and the appointment of defense counsel under AS 47.30.705.

- The Alaska Court System form MC-404 explains the rights of respondents held under an emergency detention.
- The form MC-405 explains the rights of respondents who are being held at an evaluation facility.

The MC-305 order requires that respondents at an evaluation facility must be given the MC-405, but does not mention the MC-404.

DHSS asks that the Alaska Court System modify the MC-305 to require that the respondent receive the MC-404 form by all referring facilities. DHSS, particularly the DES/DET coordinator's office, will encourage all partners to include these notifications, but cannot enforce such change without amendments to the court form and/or state law.

Alternatively, the Alaska Court System could consider combining MC-404 and MC-305 into a single form.

OTHER CONSIDERATIONS:
FUTURE LONG-TERM WORK ON THE BEHAVIORAL HEALTH SYSTEM

MOVING FORWARD WITH PARTNERS[25]

As a measure of continuous quality improvement of the behavioral health system of care, DHSS will need to engage with hospitals and multiple organizations on a variety of different issues and levels.

DHSS has an immediate focus on:

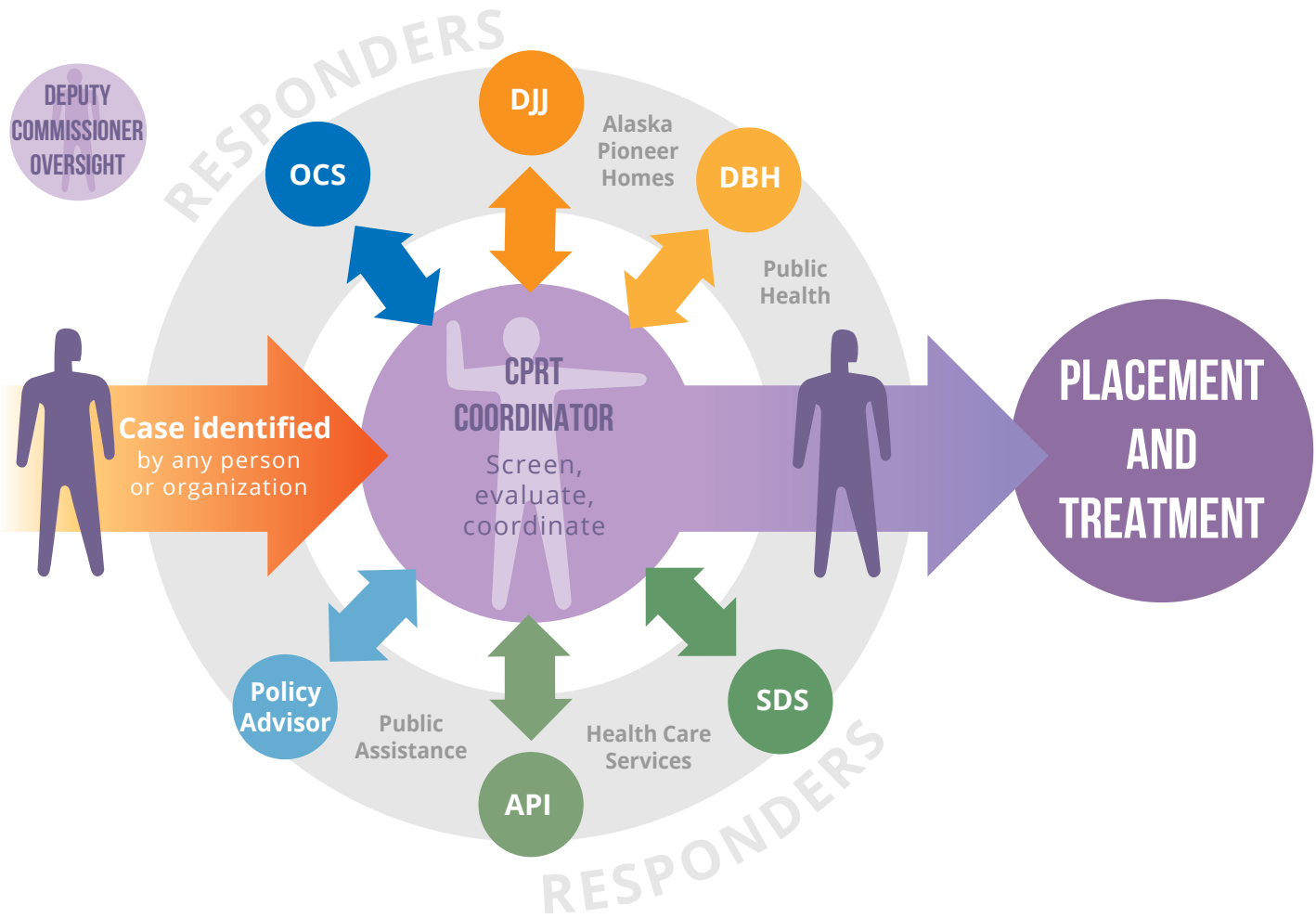
- Beginning immediately, DHSS will offer Title 47 training upon request to a state agency or community provider/partner. A clinician from DHSS and an attorney from the Department of Law will conduct this training.
- DHSS will make diligent efforts to make tele-psychiatric consultation available to hospitals.
- DHSS will generate "best practices" written materials for distribution to places holding respondents.[26]
- DHSS will coordinate and continue to work with non-DET hospitals on access to resources on topics such as on trauma informed care, as well as de-escalation techniques.
- DHSS will coordinate with law enforcement and hospitals on patients arriving at hospitals versus DOC facilities, to promote patient care and staff safety at all levels.
- DHSS will work to connect API to the Emergency Department Information Exchange known as EDIE. EDIE is an electronic health information-sharing program, which would allow EDs easier access to patient records. This process has already begun and was presented to the API governance board on December 19, 2019.
- DHSS will continue to explore and improve communication with referring hospitals related to readmission, but at minimum will ensure API's admission and screening officers are available for clinical consultation to hospitals if a patient presents within 48 hours of discharge from API.
- DHSS will continue to work with its partners across the state to support a full continuum of care including crisis stabilization.
- DHSS will amend/update its Division of Behavioral Health DES/DET manual.
- DHSS will assist in improving reimbursement options for facilities that provide emergency psychiatric care including working on the hospital presumptive eligibility process (Medicaid eligibility).
- DHSS will continue to reimburse facilities for emergency department boarding up to 120 hours through June 30, 2020 (which extends reimbursement beyond the current rule of 24 hours).

25. This includes: ASHNHA, current DES/DET facilities, the Trust, the Disability Law Center, state employee unions, community behavioral health providers, DOC, local police and Alaska State Troopers, the Alaska Legislature, and the Centers for Medicare and Medicaid Services.

26. See Appendix B: SMART Emergency Department Medical Clearance Form.

OTHER CONSIDERATIONS: (CONT.)
FUTURE LONG-TERM WORK ON THE BEHAVIORAL HEALTH SYSTEM

DHSS CRISIS PLACEMENT RESPONSE TEAM



- DHSS has established a Crisis Placement Response Team (CPRT), which is activated when it is notified of an individual who has exhausted community placement resources and needs intervention and assistance with discharge planning. Providers can choose to reduce the likelihood of a petition by proactively contacting DHSS for technical assistance of the CPRT in emergencies.
- DHSS will create a standing multi-disciplinary workgroup, which will meet on a regular basis to discuss system issues, patient care, staff safety, and discharge planning. This team shall consist of senior officials from Division of Senior and Disability Services, Office of Public Advocacy (OPA)/ Public Guardian, Public Defender Agency, Alaska Psychiatric Institute, Division of Health Care Services, Division of Behavioral Health, and the Department of Corrections.

OTHER CONSIDERATIONS: (CONT.)
FUTURE LONG-TERM WORK ON THE BEHAVIORAL HEALTH SYSTEM

WORKING WITH PARTNERS TO EXPLORE TIMELY IMPLEMENTATION OF NEW PROGRAMS IN THE CRISIS NOW MODEL

IMPROVED STATEWIDE CALL CENTER

A key component of any good system of care is having good data and care coordination, which can be achieved by implementing a statewide call center. Under this plan, call centers have the potential to stabilize a majority of crisis situations without an emergency department visit or other intervention, connect patients to next-day appointments as well as connect hospitals to available inpatients beds. As explained above, Alaska has the Careline call system, but there is room to implement a more robust call center. Key components of a robust call center include:

- Crisis services 24/7.
- Connect patients to either urgent physical appointments or tele-health services.
- Connect different levels of care for bed availability, such as moving a patient from an emergency department to an inpatient bed.
- Unified IT platform that connects different data sources and allows data analytics.

Key components of an Alaska[27] specific model would also include:

- A hub and spoke model to support regional care models.
- Culturally-aware care.

DHSS supports working with different stakeholders to streamline these services to a more integrated complete call center model (e.g., Crisis Now).

MOBILE CRISIS TEAMS

Secondary to the statewide call center is the development of mobile crisis teams that consist of two-person teams (a licensed clinician and a peer support person) who offer assessment, outreach and support where people are in crisis – they go to the person, rather than the person coming to them. This could also include some Global Positioning System (GPS) functionality so that the mobile teams will know where to go and who needs assistance. These teams will have required response times and will include medical support as necessary. These services would be 24/7, and would be a bridge to higher level of support, including referral and transportation (if appropriate) to a crisis stabilization and/or hospitalization facility. It is important to note that this option is

27. Currently, parts of what could be considered for a statewide call system are in place or being built including: Alaska State Troopers central call line, Alaska Care Line, 1115 contract for the Administrative Services Organization (ASO), DHSS contract with "Open beds" for bed availability, 2-1-1, State Health Information Exchange (HIE), and the ASHNHA real-time information exchange for emergency rooms via "Collective" or "EDIE".

OTHER CONSIDERATIONS: (CONT.)
FUTURE LONG-TERM WORK ON THE BEHAVIORAL HEALTH SYSTEM

being implemented under the 1115 Waiver (see below).

DHSS supports working with stakeholders to explore implementation of these services.

CRISIS STABILIZATION

This is a facility-based, short-term service that is located within a community to provide support and observation to persons suffering from a behavioral health event/crisis. These facilities are clinically and medically staffed, and provide a safe and secure location for persons, including those who might otherwise be subject to an *ex parte* order, to stabilize. This is a "no- wrong-door" program, which implements a high-speed observation of the client, evaluation which will lead to engagement and stabilization. This includes a risk assessment, medical and medication evaluation, and substance use disorder (SUD) evaluation. These evaluations will lead to an increase in stabilization and discharge planning to the community for coordinated and long-term services. It is important to note that this option is being implemented under the 1115 Waiver (see below).

DISCHARGE PLANNING ACROSS THE STATE

One of the major issues with capacity is the lack of appropriate options for discharge from API or the DES/DET system or DOC. One of the major components of DHSS efforts to effect change is to develop better options for discharge planning, including how these facilities interact with Adult Protective Services (APS) and the Office of Public Advocacy (OPA).

SUCCESSFULLY IMPLEMENTING THE 1115 WAIVER

As part of a long-term solution, DHSS will make diligent, ongoing efforts to meet with the Trust, coordinate the implementation of this plan with the work on a crisis stabilization center, and leverage the rollout of the 1115 Waiver - the Substance Use Disorder Treatment and Alaska Behavioral Health Program.

LEGISLATIVE AND APPROPRIATION ITEMS

In order to implement this plan, the Governor will submit the following appropriations as part of the FY 2021 budget for legislative consideration. In addition, DHSS has discussed possible financial partnership with the Trust on some of these items. This plan is subject to revision and to legislative appropriation.

Proposed Appropriations:

1. Positions and Contractors:
    a. DES/DET coordinator Position housed in Commissioner's Office.
    b. Adult Protective Services III position housed in Division of Senior & Disabilities Services (SDS).
    c. Provider agreements for Mental Health Professionals (MHP).
    d. Fund Crisis Placement Provider Agreements for placement of civil psychiatric patients.

2. General Fund (GF) funding for services
    a. No additional reductions in FY 2021 for state funded behavioral health grant programs. These grants fund services that are not yet reimbursable under the 1115 waiver or Medicaid.
    b. Provide DES/DET administrative grants to assist in offsetting the cost of operating these programs on behalf of DHSS.
    c. Medicaid Disproportionate Share Hospital (DSH) funding.
    d. Increased DET Secure Transport.

OTHER CONSIDERATIONS: (CONT.)
FUTURE LONG-TERM WORK ON THE BEHAVIORAL HEALTH SYSTEM

DHSS will continue to work on behavioral health systems improvements that will have potential future year fiscal impacts or statuary changes including:

1. Full Operation of API.
2. Implementation of Crisis Now Model.
3. Federal and State Statutory or Regulatory Changes:
    a. Contingent upon continued federal funding, DHSS will amend DSH regulations as allowed per the federal program rules to improve ability for more facilities to apply for and be eligible for DSH.
    b. Continue to seek federal waiver of Institutions for Mental Disease (IMD) exclusion. DHSS is engaged in these discussions through our 1115 waiver negotiations.
    c. Continue annual evaluations of state statutes and regulations to amend/update/improve the Title 47 system of care.

APPENDIX A:
PSYCHIATRIC EMERGENCY SERVICES (PES) AGENCIES

PROVIDER NAME	CITY
Akeela, Inc. - GCHS	Ketchikan
Aleutian Pribilof Islands Association	Anchorage
Bristol Bay Area Health Corporation	Dillingham
Central Peninsula General Hospital	Kenai/Soldotna
Copper River Native Association	Copper Center
Cordova Community Medical Clinic - SA	Cordova
Eastern Aleutian Tribes	Anchorage
Fairbanks Community Mental Health Services	Fairbanks
JAMHI Health & Wellness	Juneau
Juneau Youth Services	Juneau
Maniilaq Association	Kotzebue
Mat-Su Health Services, Inc.	Palmer/Wasilla
North Slope Borough	Utqiaġvik
Norton Sound Health Corporation	Nome
Petersburg Mental Health Services	Petersburg
Providence Crisis Recovery Center	Anchorage
Providence Kodiak Island Counseling Center	Kodiak
Providence Valdez Counseling Center	Valdez
Railbelt Mental Health & Addictions	Nenana
Seaview Community Services	Seward
Sitka Counseling and Prevention Services	Sitka
South Peninsula Behavioral Health Services, Inc.	Homer
Southeast Regional Health Consortium	Sitka
Southeast Regional Health Consortium – LCCS	Haines
Southeast Regional Health Consortium – AKICS	Wrangell
Southcentral Foundation	Anchorage
Southcentral Foundation	McGrath
Tanana Chiefs Conference, Inc.	Fairbanks
Tanana Chiefs Conference, Inc.	Interior region
Yukon-Kuskokwim Health Corporation	Bethel

APPENDIX B:
SMART FORM

SMART Emergency Dept. Medical Clearance Form **Psychiatric Inpatient**	**No***	**Yes**	**Time** (*Cleared or N/A*)
Suspect *new onset* psychiatric condition?	1		
Medical conditions that require screening?	2		
Abnormal	3		
Vital signs?			
Temp: greater than 38.0°C (100.4°F)			
HR: less than 50 or greater than 110			
BP: less than 100 systolic or greater than 180/110 (2 consecutive readings 15 min apart)			
RR: less than 8 or greater than 22			
O_2: less than 95% on room air			
Mental status?			
Cannot answer name, month/year and location (minimum A/O x 3)			
If clinically intoxicated, HII score 4 or more? (next page)			
Physical exam (unclothed)?			
Risky presentation?	4		
Age less than 12 or greater than 55			
Possibility of ingestion (screen all suicidal patients)			
Eating disorders			
Potential for alcohol withdrawal (daily use equal to or greater than 2 weeks)			
Ill-appearing, significant injury, prolonged struggle or "found down"			
Therapeutic levels needed?	5		
Phenytoin			
Valproic acid			
Lithium			
Digoxin			
Warfarin (INR)			
Notes			

A/Ox3 = Alert and oriented x 3 (person, place, time) • FSBS = Finger stick blood sugar • HII score = H-Impairment index score
INR = International normalized ration• O_2 Sat = blood oxygen saturation

***SMART Total:** If ALL five SMART categories are checked "NO" then the patient is considered medically cleared and no testing is indicated. If ANY category is checked "YES" then appropriate testing and/or documentation of rationale must be reflected in the medical record and time resolved must be documented above.

Date: _____ **Time:** _____ **Completed by:** _____
Print

_____, **MD/DO**
Signature

Visit the http://smartmedicalclearance.org website for research, references, frequently asked questions and more about the SMART Medical Clearance form.

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APPENDIX B:
SMART FORM - PAGE 2

SMART Emergency Dept. Medical Clearance Form **Psychiatric Inpatient**	**Notes***
Other considerations for all patients	
Patient age	
Current location	
When patient arrived at facility	
When patient was placed on hold (MC-105)	
When MC-100 was filed	
Is the patient likely to stabilize in the next 48 hours?	
Has the patient needed emergency psychotropic medication? Is so, when and was it voluntary?	
Has patient needed physical restraints? If so, when was last use?	
Does patient require medical equipment (wheelchair, walking, oxygen, etc.)	
Communicable infectious disease (lice, scabies etc.)	
Other clinical conditions not listed	

**Documentation of rationale must be reflected in the medical record.*

Hospital-Specific Clinical Admission Criteria

Alaska Psychiatric Institute

API is a free-standing psychiatric care facility with a limited ability to care for acute medical conditions and has no on-site imaging or laboratory services. API cannot take patients who need IV therapy, negative pressure isolation, cardiac or fetal monitoring, acute dialysis (home dialysis can be accommodated), or daily physical therapy. API can take patients with mobility problems including those with prostheses, in wheelchairs, and who need assistance with mobility and some activities of daily living (ADLs), but not those who require a "total assist" level of care.

Bartlett Regional Hospital

Criteria is pending review by Bartlett Regional Hospital.

Fairbanks Memorial Hospital

Criteria is pending review by Fairbanks Memorial Hospital.

Mat-Su Regional Hospital

Criteria is pending review by Mat-Su Regional Hospital.

Visit the http://smartmedicalclearance.org website for research, references, frequently asked questions and more about the SMART Medical Clearance form.

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