

Potential Enhancements to Alaska's Behavioral Health Crisis Continuum

Sponsored by Alaska Department of Health, Division of
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Introduction and Background

ENGAGEMENT AND PURPOSE

The Alaska Department of Health (DOH), working through its Division of Behavioral Health (DBH), engaged Milliman, Inc. (Milliman) to identify opportunities to further strengthen and develop the state's behavioral health crisis care continuum. The initiative built upon the findings of a comprehensive [2024 assessment](#) of Alaska's crisis services. The primary goal the current project was to expand both the availability and effectiveness of behavioral health crisis care programs, addressing the needs of Alaska's diverse communities and the providers who serve them.¹

2024 ASSESSMENT: APPROACH AND KEY THEMES

The 2024 assessment integrated a review of regulatory frameworks, research into national best practices, and feedback from stakeholders statewide. This multi-faceted approach resulted in a thorough qualitative and quantitative analysis of Alaska's behavioral health crisis services. The assessment identified five main opportunity areas:

- 1) Enhancing the crisis service array
- 2) Streamlining documentation
- 3) Providing additional support for providers and community partners
- 4) Improving sustainable financing
- 5) Facilitating collaboration

Additionally, the report offered initial considerations for implementation, which are explored further in this report. For those seeking further context or a detailed understanding of Alaska's crisis continuum, the [2024 assessment](#) serves as a foundational resource, providing comprehensive insights into the current landscape.

Drawing on the findings and recommendations identified in the 2024 assessment, DBH decided to **focus this project on initiatives to enhance the crisis service array**. Specifically, the focus was on identifying where, what, and how adjustments to the current services – or the creation of new ones – could expand access to and delivery of behavioral health crisis care across Alaska. This included suggestions to increase flexibility within current service requirements and evaluate additional options for place-based care. While the 2024 assessment offered a comprehensive landscape analysis of Alaska's behavioral health crisis system, the primary objective here was to develop **actionable implementation recommendations** designed to strengthen the behavioral health crisis continuum, with an emphasis on practical solutions tailored to Alaska's unique context and the specific needs of its communities.

BACKGROUND AND FOCUS OF CURRENT PROJECT

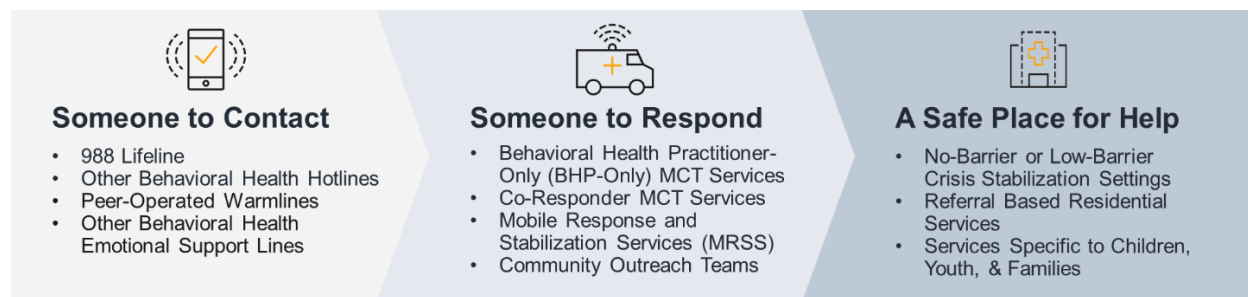
National Context: Updated Guidelines

In addition to the 2024 assessment, this project was also driven by the **release of updated guidelines and model service definitions** by the U.S. Substance Abuse and Mental Health Service Administration (SAMHSA) in January 2025.² Like the earlier version of the guidelines, SAMHSA defines three critical elements for an integrated crisis care system, see Figure 1:

¹ Cunningham, J., Bertolo, J., Schulze T., Applegate, D., Latet, K., Hybels, M. (June 2024). Assessment of Alaska's behavioral health crisis services continuum of care. Milliman. <https://us.milliman.com/en/insight/assessment-alaska-behavioral-health-crisis-services>

² Substance Abuse and Mental Health Services Administration. National Behavioral Health Crisis Care Guidance. (Updated 16 January 2025) <https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care>

FIGURE 1. ESSENTIAL ELEMENTS OF BEHAVIORAL HEALTH CRISIS CARE SYSTEM



- 1) **Someone to Contact:** Services like the 988 Lifeline and other behavioral health hotlines provide immediate, accessible support.
- 2) **Someone to Respond:** Services like mobile crisis teams (MCT) deliver rapid, on-site interventions to de-escalate crises and connect individuals to care and other community-based supports that provide crisis intervention and postvention care.
- 3) **A Safe Place for Help:** Emergency and crisis stabilization services that support on-demand crisis care and crisis-related supports in a variety of community settings.

For this initiative, DBH directed Milliman to **focus on the elements of mobile crisis response services (“Someone to Respond”) and place-based stabilization services (“Safe Place for Help”)**, to strengthen Alaska’s crisis services using the new SAMHSA guidance as a model. These two topics comprise the major sections of this report.

State Context: Alaska’s Current Crisis Continuum

The current crisis continuum in Alaska includes seven crisis services authorized through the Medicaid State Plan via a 2010 state plan amendment (SPA) and Alaska’s Behavioral Health Reform 1115 Demonstration Waiver (1115 Waiver), which was approved in two phases over 2018 and 2019. Figure 2 provides a summary of the different crisis services along with their implementation authority, corresponding citations in the Alaska Administrative Code (AAC), and relation to the core elements defined by SAMHSA.

FIGURE 2. ALASKA BEHAVIORAL HEALTH CRISIS SERVICES

Authority	Service Name	Description	Administrative Code	Crisis System Element
State Plan	Short-Term Crisis Intervention	Short-term mental health services provided to a recipient during an acute episode of a mental, emotional, or behavioral disorder	7 AAC 135.160	These services do not necessarily fit squarely within a single part of the continuum (as defined by SAMHSA) to the extent they contain components of mobile crisis response and crisis receiving and stabilization.
	Short-Term Crisis Stabilization	Any medically necessary and clinically appropriate behavioral health rehab services necessary to return recipient to the mental, emotional, and behavioral level of functioning before short-term crisis occurred	7 AAC 136.170	
1115 Waiver	Mobile Outreach and Crisis Response (MOCR) Services	Provided to prevent a mental health crisis or to stabilize an individual during or after a mental health crisis	7 AAC 138.450 7 AAC 139.350	Someone to Respond

Authority	Service Name	Description	Administrative Code	Crisis System Element
	MOCR Crisis Service Follow Up	Provided to ensure connection to resources and/or ensure the crisis has stabilized. The follow up continues to assess for safety and confirms linkage with any referrals.	7 AAC 138.450 7 AAC 139.350	
	23-Hour Crisis Stabilization Observation	Provide prompt observation and stabilization in a secure environment for individuals at imminent risk of or presently experiencing acute mental health symptoms or emotional distress	7 AAC 138.450 7 AAC 139.350	A Safe Place for Help
	Crisis Residential Stabilization	Short-term residential, medically monitored stabilization service for individuals presenting with acute mental or emotional disorders requiring psychiatric stabilization	7 AAC 138.450 7 AAC 139.350	
	Peer-Based Crisis Services	Help individuals experiencing crisis to avoid need for hospital ED services or psychiatric hospitalization; other therapeutic activities to reduce or eliminate emergent/crisis situation to support individual or family of individual in crisis	7 AAC 138.450 7 AAC 139.350	

While the 2024 assessment examined the full range of crisis services across the State Plan and 1115 Waiver, this project focused mainly on the **service standards relevant to the 1115 Waiver**. In relation to *Someone to Respond* and *A Safe Place for Help*, this meant an emphasis on Mobile Outreach and Crisis Response (MOCR), MOCR Crisis Service Follow-Up (MOCR Follow-Up), 23-Hour Crisis Stabilization and Observation, Crisis Residential Stabilization, and Peer-Based Crisis Services.

Of particular relevance to the place-based stabilization services within *A Safe Place for Help*, the 2022 passage of **House Bill 172** (HB172 and referenced in this report as “Alaska’s Subacute Facility Licensure”) created **two new sub-acute facility types – crisis stabilization centers (CSCs) and crisis residential centers (CRCs)**. During stakeholder sessions for both the 2024 assessment and this project, providers said the interim, temporary licensing rules for sub-acute facilities are unclear and burdensome, deterring investment in CSC/CRC capacity; they recommended clearer standards, step-down levels of care, and a tiered payment model.

Stakeholders reported that providers interested in providing place-based crisis services have either stopped providing services or have been hesitant to develop new facilities and capacity due to the uncertainty of the licensure requirements. Claims data analyzed as part of the 2024 assessment indicated a reduction in claims for 23-Hour Crisis Stabilization and Observation by 45.8%, and Crisis Residential Stabilization by 77.8%, between March and June of 2023. These claim trends coincide with the passage of HB 172.

The state seeks to ensure that implementation of new Alaska’s Subacute Facility Licensure requirements is accompanied by a fully developed continuum of place-based crisis services, particularly for providers unable to meet subacute requirements associated with higher levels of care. This need to strengthen the continuum created a clear impetus for this project.³

³ Information on licensure of subacute mental health facilities can be found online: <https://health.alaska.gov/en/services/health-care-facilities-licensing-certification-all/subacute-mental-health-facilities/>

PROJECT APPROACH

The project team reviewed national best practices and guidelines and gathered input from stakeholders across Alaska. This information was used to develop recommendations that are based on both current evidence and the practical experiences of providers of behavioral health crisis care across the state.

Review of updated guidelines. Following the release of the 2024 assessment, SAMHSA issued revised guidance and resources.⁴ Accordingly, the project began with an evaluation of the *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care* and the *2025 Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services*.^{5,6} Building on the foundation of the 2024 assessment, Milliman conducted a comparative analysis of the service standards for the 1115 Waiver services against the guidance set forth in SAMHSA's 2025 national guidelines and model definitions.⁷ While these documents provided a baseline for establishing comparison benchmarks, the primary objective of the project was to develop a crisis continuum of care tailored to the unique needs and circumstances of Alaskan communities.

After reviewing SAMHSA's 2025 national guidelines and model definitions, and consulting with DBH regarding the alignment of 1115 Waiver service standards with these national frameworks, Milliman undertook a detailed, structured stakeholder engagement process. This initiative focused on both mobile crisis response services and place-based stabilization services. The stakeholders who participated in the surveys, interviews, and focus groups throughout the project are listed in *Appendix A*.

Initial stakeholder engagement. The preliminary stage of stakeholder engagement involved administering surveys to pertinent service providers, supplemented by a series of focus groups and individual interviews. Participants included both providers and key stakeholders whose insights were essential for evaluating the existing system. The discussions evaluated Alaska's crisis services in comparison to national guidelines and established model definitions, with attention given to Alaska's unique circumstances and needs to identify opportunities for improvement and enhancements, including possible introduction of new services. The overarching objective was to understand what was needed to expand provider capacity and improve statewide access to crisis care.

System design and stakeholder feedback. Following the initial stakeholder engagement, Milliman analyzed information collected from surveys, focus groups, and interviews. Perspectives from service providers and key stakeholders informed the development of recommendations for modifying the current service array, as well as strategies and actionable steps for implementation. The proposals were subsequently presented for further review and discussion during two focus group sessions held in August to assess their feasibility and alignment with identified needs.

Final report. The iterative process—combining updated guidelines, stakeholder engagement, and ongoing feedback—culminated in the final set of recommendations presented in this report. The document is organized into sections addressing mobile crisis response services and place-based stabilization services.

⁴ Substance Abuse and Mental Health Services Administration. *National Behavioral Health Crisis Care Guidance*. (Updated 16 January 2025) <https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care>

⁵ Substance Abuse and Mental Health Administration: 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. PEP24-01-037: Substance Abuse and Mental Health Services Administration, 2025. <https://988crisisystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf>

⁶ Substance Abuse and Mental Health Services Administration: Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services. HHS Publication No. PEP24-01-037: Substance Abuse and Mental Health Services Administration, 2025. <https://988crisisystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf>

⁷ Provider manuals containing service standards for the 1115 Waiver services can be found online: <https://health.alaska.gov/en/services/behavioral-health-medicaid-provider-support/>

Mobile Crisis Response Services

Mobile crisis response services are designed to deliver rapid, on-demand, in-person support to individuals experiencing a behavioral health crisis regardless of where they are located in the community. While team structures may vary, SAMHSA's guidance recommends that mobile crisis teams should include a licensed or credentialed behavioral health clinician.⁸

Access to mobile crisis response services across Alaska is inconsistent, with notable variation from one community to another. While Alaska shares many of the challenges other states face in developing mobile crisis services – such as workforce limitations and financial sustainability – it also contends with particularly acute geographic barriers. Delivering a rapid, in-person response in many frontier communities, some of which have small populations and are not accessible by roads, presents a unique challenge in the context of mobile crisis response teams.

Currently, few providers are able to fully adhere to the state's current Mobile Outreach and Crisis Response (MOCR) service standards.⁹ Providers report that existing Medicaid reimbursement rates fall short of covering the actual cost of delivering these services. Consequently, many organizations depend on supplemental funding from grants and municipal sources to continue operations.

This assessment found that some challenges confronting mobile crisis response providers may be addressed in the short-term through targeted actions, while others will require thoughtful, longer-term solutions. DBH should evaluate immediate steps to improve sustainability and access for providers, even as broader system improvements are considered for the future.

SHORT-TERM APPROACH: REVISE CURRENT SERVICE STANDARDS AND RATES

In the near term, DBH can focus on practical adjustments that will create more stability and sustainability for providers currently delivering mobile crisis response, and those interested in doing so. By refining the operational and financial frameworks, the state can help providers better meet the needs of individuals in crisis, even as broader system improvements potentially unfold in the future.

Update Service Standards

DBH could implement targeted modifications to the current MOCR and MOCR Crisis Service Follow-Up (MOCR Follow-Up) service definitions. Increasing flexibility in existing service standards could facilitate service delivery and expand access in communities where the current 1115 Waiver service requirements have created difficulties. These adjustments are designed to address barriers to service provision in the short-term, with the possibility of broader changes in the future as the system develops.

Appendix B outlines all potential revisions under consideration by DBH; the primary proposed changes include:

- **Hours of operation:** The current MOCR service definition requires providers to offer services around the clock, every day. However, many providers are unable to meet this standard, and in rural or frontier regions, such constant availability may not reflect the needs of the community.

Appendix B recommends DBH add flexibility to this requirement by changing the service standard from “*must* be available” to “*should* be available” 24/7, year-round. It also notes that providers unable to meet this should offer the broadest service window possible, based on community needs.

- **Staffing:** MOCR teams are currently required to provide a two-person, in-person response with both a mental health clinician and a qualified behavioral health provider (QBHP), while telehealth is available for rural and frontier programs. The national standard recommends that states and providers utilize teams of

⁸ Substance Abuse and Mental Health Administration: 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. PEP24-01-037: Substance Abuse and Mental Health Services Administration, 2025. <https://988crisisystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf>

⁹ Provider manuals containing service standards for the 1115 Waiver services can be found online: <https://health.alaska.gov/en/services/behavioral-health-medicare-provider-support/>

two behavioral health staff (such as a clinician and peer or paraprofessional) for in-person responses; however, workforce limitations can make this challenging.¹⁰

DBH should continue to support the delivery of a two-person, in-person response by behavioral health professionals when it is possible and appropriate. However, additional options could be considered for mobile crisis response providers if alternative team structures beyond the clinician and peer or paraprofessional model are permitted, including the use of telehealth where applicable. Examples of different team structures are presented in *Appendix B*.

- **Modifiers and bifurcation of mental health and substance use:** Providers delivering mobile crisis response services currently use code T2034, with modifiers V1 and V2 to distinguish between substance use and mental health crises. In practice, however, many crisis situations involve co-occurring conditions or do not fit neatly into one category. This bifurcation of mental health and substance use has led to confusion for providers.

To simplify the billing process, DBH could consider removing these specific modifiers, allowing providers to use the same code for any type of crisis. This change would make it easier for providers to submit claims, regardless of the nature of the crisis encountered. If implementing this approach, DBH should consider downstream impacts to reporting processes such as allocation of expenditures for 1115 Waiver budget neutrality reporting.

If DBH adopts greater flexibility in service hours and team staffing models, there will be a need to introduce new modifiers. These additional modifiers would capture whether a program offers 24/7 service or has limited hours, as well as details about the team's composition. By doing so, reimbursement rates can be adjusted to reflect the unique operational and staffing costs associated with each model. This approach would help ensure more accurate funding and support for providers as they respond to varying community needs.

- **MOCR Crisis Service Follow-Up:** The MOCR Follow-Up service standards do not require substantive modifications. *Appendix B* outlines potential areas for DBH to improve alignment between MOCR and MOCR Follow-Up definitions by eliminating redundant or conflicting language and clarifying that MOCR refers to the initial response while MOCR Follow-Up pertains to subsequent support or care coordination for the individual.

Implementation Planning: MOCR and MOCR Follow-Up services are **currently authorized under the state's 1115 Waiver**.¹¹ DBH should verify with internal counsel, but generally, as long as these proposed changes remain consistent with the 1115 Waiver, Alaska has the authority to implement recommended updates to these service standards without needing external approval by Centers for Medicare & Medicaid Services (CMS) through an amendment to its 1115 Waiver.

Additionally, DBH may wish to consider **whether to move the federal authorization for these services from the 1115 Waiver to Alaska's Medicaid State Plan**. If this approach is chosen, DBH would need to amend the 1115 Waiver to no longer request expenditure authority for MOCR and MOCR Follow-Up and follow CMS's standard state plan amendment (SPA) process to authorize the services under Alaska's Medicaid State Plan.

Although some of the proposed adjustments might call for amendments to regulations such as 7 AAC, 138.450, or 7 AAC 139.50 (potentially triggering the need for a public comment process), the majority of updates can be made without significant modifications to existing regulations or operational processes.¹² This internal flexibility allows DBH to efficiently update the service standard manuals and implement necessary revisions to service definitions, thereby streamlining improvements as described.¹³

¹⁰ Substance Abuse and Mental Health Administration: 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. PEP24-01-037: Substance Abuse and Mental Health Services Administration, 2025. <https://988crisisystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf>

¹¹ Centers for Medicare & Medicaid Services. Alaska Behavioral Health Reform. (March 24, 2024). <https://www.medicare.gov/medicaid/section-1115-demonstrations/downloads/ak-behavioral-health-refm-aprvl-03262024.pdf>

¹² Relevant sections of the Alaska administrative code include: [7 AAC 135.160](#); [7 AAC 135.170](#); [7 AAC 138.450](#); [7 AAC 139.350](#).

¹³ Service standards can be accessed here: <https://health.alaska.gov/en/services/behavioral-health-medicare-provider-support/>

Lastly, as discussed further below, the state will need to consider budgetary realities when making updates to service definitions. Changes will need to be financially sustainable for both the state and providers, without compromising the quality or accessibility of services for individuals in need.

Targeted Rate Review

Providers consistently reported that the current MOCR reimbursement rate does not sufficiently cover the costs associated with delivering services. The forthcoming DOH rate study presents an important opportunity to better align reimbursement rates with actual service delivery expenses.

During the rate study, it is essential for DOH to comprehensively evaluate all costs related to updated service standards and integrate them into the overall cost analysis. This is particularly critical regarding team staffing structures and hours of operation. Although the revised service standards will introduce greater flexibility in these areas, it is recommended that DBH implement **tiered rates for MOCR services** to reflect **variations in team staffing models and the extent of provider operational hours**—specifically whether providers offer 24/7 coverage or operate on a more limited schedule.

For staffing, tiered rates could address the costs associated with various types of staff and whether the response is conducted in-person or through telehealth. If reimbursement for MOCR services remains through fee-for-service, these tiered rates could also include enhanced payments for programs providing round-the-clock coverage.

Implementation Planning: DOH has already committed to conducting the rate study, eliminating the need for additional contracting processes or state legislative funding requests. Although conducting a rate study does not guarantee changes to reimbursement rates, it is important for the state to consider all relevant factors during the rate study process to ensure any adjustments made are informed and appropriate.

Identification of Medicaid Status

Providers participating in focus groups noted difficulties with verifying and accessing insurance information, particularly in the context of mobile crisis response services, which can be urgent and unpredictable. If providers cannot verify an individual's insurance information, they are unable to submit claims for reimbursement for those services. Providers of mobile crisis response services face this challenge in many places, not just Alaska. Although no single solution exists for this issue, the state can take steps to help address the challenge faced by providers.

DBH could create standard screening tools, questionnaires, or guidance for mobile crisis response providers to help identify a person's Medicaid status more effectively. While this approach may not solve every case, it would give providers an additional way to verify Medicaid eligibility and access necessary information.

Implementation Planning: DBH can independently create tools or guidance to help mobile crisis response providers identify Medicaid status. When developing these resources, DBH should consider provider input to ensure effectiveness and relevance to real-world field conditions.

Funding

The state could use non-Medicaid funds to help uninsured individuals, acknowledging that some may be used for Medicaid-eligible individuals not identified during crisis response. This would reduce financial pressure on providers and help sustain mobile crisis response in Alaska.

Implementation Planning: This may require appropriation of state general funds through the legislative process. It is also possible that grant funding and/or municipal funds could be leveraged to support service delivery in situations where an individual's insurance information cannot be verified. Regardless of the funding source, DBH should collaborate with providers to estimate the number of responses where an individual's Medicaid status cannot be verified (at the same time it works with providers to better identify individual's Medicaid status, as suggested above).

LONG-TERM STRATEGY: BUILDING A MOBILE CRISIS RESPONSE PROGRAM

As immediate adjustments are made to service standards and reimbursement rates, DBH can also lay the groundwork for solutions that address broader, long-term needs. While short-term changes focus on refining the MOCR *service* standards, a comprehensive strategy for the future could include developing a robust mobile crisis response *program* that systematically addresses persistent challenges and supports the sustainability and effectiveness of crisis services.

Tiered Mobile Crisis Response Program

Mobile crisis response services in Alaska currently operate under a fee-for-service reimbursement model, with providers compensated for each service unit delivered. This includes payment for each call-out and for every 15-minute interval for both MOCR and MOCR Follow-Up services. Short-term adjustments focus exclusively on refining service definitions and do not alter the foundational payment approach. However, given the unique nature of mobile crisis response, there is an opportunity for DBH to assess whether a more comprehensive program—beyond existing service standards—could enhance the sustainability and effectiveness of these services. Evaluating broader programmatic strategies may help address persistent challenges and support providers more robustly over the long-term.

Key components for such a program would include:

- **Program Standards:** Establish clear, detailed criteria outlining requirements for organizations interested in operating MOCR teams. At a minimum, these standards should cover critical elements such as staffing levels, 24/7/365 service availability, and eligible provider types. Additionally, operational guidance should address response time expectations and specifications for response vehicles, ensuring consistency and reliability across all providers. For reference, Washington’s Mobile Crisis Response Endorsement Program offers a useful model: <https://www.hca.wa.gov/billers-providers-partners/program-information-providers/mobile-crisis-response-endorsement-program>.
- **Lower Tier Program Payment Model:** For teams unable to meet the program standards—or for communities that do not require a 24/7/365, at-the-ready response—DBH could retain the current MOCR service and/or introduce a lower tier program option, with reimbursement scaled to the reduced requirements.
- **Firehouse Payment Model:** As previously noted, providers have consistently indicated that current reimbursement rates do not adequately reflect the actual costs associated with service delivery. Although the forthcoming rate review may partially address these concerns, as a long-term strategy, DBH may wish to explore the implementation of a “firehouse” payment model—an approach utilized in funding EMS, fire, and police services, and also recommended by SAMHSA.¹⁴ This model would integrate multiple funding streams—not limited to Medicaid—into a consolidated payment for MOCR providers.

The underlying premise of this approach is that reimbursement, whether through a unit-based rate or a fixed monthly payment, is designed to cover all operational expenditures for the provider, *including staff downtime to maintain continuous readiness*. Such a reimbursement framework could improve the financial sustainability of mobile crisis response services by compensating providers both for their availability and for the services rendered, thus mitigating the challenges posed by fluctuating utilization rates typical of these services.

Additionally, building upon the concepts discussed within short-term strategies, the reimbursement structure for such a program could incorporate a **tiered payment mechanism**. Determining the number of tiers, payment levels, specific reimbursement structures, and related considerations would require careful deliberation by DBH. For example, this could entail implementing some form of firehouse payment for providers who satisfy specified standards, while maintaining the current fee-for-service structure for other providers. More specifically, because service needs vary, maintaining the existing fee-for-service payment system may better align with community needs in Alaska’s less populated areas than adopting a firehouse payment model.

Implementation Planning: The specific steps for implementation will depend on the policy choices and program design decisions made by DBH during the development process of such a program. However, generally, DBH must determine and act on key factors such as:

- **Financing and payment structure:** As outlined above, a more comprehensive program would likely necessitate further review of the payment model used to reimburse providers operating MOCR teams, such as the firehouse model. Regardless of the payment approach, as DBH expands its program, it will **need to**

¹⁴ Substance Abuse and Mental Health Administration: 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. PEP24-01-037: Substance Abuse and Mental Health Services Administration, 2025. <https://988crisisystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf>

evaluate associated costs and ensure these are reflected in the payment rate to support ongoing sustainability and continued access.

As suggested in the context of the short-term strategies, DBH will need to **decide whether it would like to pursue a tiered payment approach** reflective of varying costs – e.g., providers that meet defined standards, services provided in rural/frontier communities.

- **Implementation authority:** DBH would need to seek amendment approval for the changes to the service specifications and payment methodology under the chosen federal pathway authorizing the service (state plan or 1115 Waiver).
- **Program design through structured decision-making process:** To establish comprehensive and effective program criteria, DBH must undertake a **thoughtful decision-making process that engages key stakeholders** and reflects the realities of service delivery. This will require close collaboration with providers, peer agencies, and other relevant parties to ensure the proposed model and standards are well suited to regional needs. Forming a dedicated workgroup for structured discussion and development of program protocols is recommended, alongside internal coordination among DBH staff and counterparts from other divisions or agencies.

Through this collaborative approach, DBH can produce **formalized program standards** that clearly **define provider eligibility and operational processes**, ensuring consistency and clarity throughout the system.

- **CCBHC alignment:** Certified Community Behavioral Health Clinics (CCBHC) are required to provide mobile crisis response services, either directly or by contract with a designated collaborating organization (DCO). As Alaska considers CCBHC implementation, it should align its mobile crisis standards with CCBHC program requirements to ensure consistency in service delivery throughout the state. The CCBHC program also offers DBH an opportunity to enhance and support the state's crisis system.
- **Engagement and coordination with other payers:** Behavioral health crises can affect anyone, regardless of insurance status – not just Medicaid beneficiaries. To better support the system, it would be beneficial for the state to engage and coordinate with other payers. Such an effort may require legislation establishing coverage requirements for behavioral health crisis care.

Telehealth Infrastructure

Providing crisis services in rural and frontier regions presents unique obstacles, including geographic isolation and limited transportation options. These challenges are especially pronounced within behavioral health crisis response systems, which tend to be less developed compared to other emergency services such as 911 or EMS—both in Alaska and across many areas of the United States. Accordingly, the integration of telehealth solutions is critical for ensuring effective crisis response services in many Alaskan communities.

DBH may evaluate the possibility of partnering with established emergency services—including police, fire, and EMS—to utilize existing infrastructure and processes alongside telehealth. This approach could help improve access to mobile crisis response in locations where continuous coverage is not feasible or required.

For example, Oklahoma's CCBHC program equips first responders with tablets to provide 24/7 telehealth access to mental health professionals.^{15,16} Implementing an approach similar to Oklahoma in Alaska would require initial investments in equipment, secure connectivity, and dedicated training for responders. However, service delivery could continue to be reimbursed under the state's current fee-for-service model or through the CCBHC PPS payment structure.

Implementation Planning: The primary implementation considerations and planning include the upfront acquisition of telehealth equipment and building collaborative relationships with other first responders, supported by targeted training and the development of formal protocols. Notably, Alaska already authorizes the use of telehealth for delivering MOCR services in rural and frontier communities.

¹⁵ Oklahoma Mental Health & Substance Abuse. iPads Help Law Enforcement & Others Connect People in Crisis to Mental Health Resources. (7 June 2023) Available online: <https://oklahoma.gov/odmhas/about/public-information/press-releases-and-other-news/2023/ipads-help-law-enforcement--others-connect-people-in-crisis-to-.html>

¹⁶ Oklahoma Mental Health & Substance Abuse. Comprehensive Crisis Response. (N.d.) Available online: <https://oklahoma.gov/odmhas/treatment/comprehensive-crisis-response.html>

During discussions about a potential enhanced telehealth program with stakeholders, public health nurses and behavioral health aides were suggested for coordinating with first responders. It was also noted that staff from the Office of Children's Services (OCS) frequently travel to these communities and may already have access to tablets.

Co-Response Teams

Beyond an enhanced telehealth program, *in-person* co-response teams that consist of a behavioral health professional and another first responder offer an additional method for expanding access to mobile crisis response services within telehealth programs. While these teams can involve—and are often associated with—law enforcement, SAMHSA highlights co-response models that pair behavioral health professionals with fire or EMS personnel as a potentially less stigmatizing approach to co-response.¹⁷ The Anchorage Fire Department (AFD) exemplifies this model, yet these teams have limited access to Medicaid funding as they are not enrolled as Medicaid providers.

There are limited examples and federal guidance regarding how such teams can better leverage Medicaid funding for behavioral-health crisis response. States and communities continue to consider options in this area. For instance, Washington's endorsement program allows EMS or fire-based teams to participate if they are licensed behavioral health agencies or have contracts with such agencies to qualify for Medicaid reimbursement.

Implementation Planning: In the short-term, targeted engagement and collaboration with co-response teams like AFD could help identify opportunities to better utilize Medicaid reimbursement to support service delivery. However, looking ahead, should DBH build out a more comprehensive mobile crisis response program, it might consider strategies for more intentional and deliberate incorporation of co-response teams – similar to the endorsement program being implemented in Washington.

¹⁷ Substance Abuse and Mental Health Administration: 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. PEP24-01-037: Substance Abuse and Mental Health Services Administration, 2025. Available online: <https://988crisisystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf>

Place-Based Stabilization

Place-based stabilization services, or a “safe place for help,” complement mobile crisis response by offering safe, supportive environments where individuals in crisis can receive immediate assessment, short-term care from trained behavioral health professionals, and seamless connection to ongoing treatment and recovery resources. These services foster stability, help prevent unnecessary hospitalization or incarceration, and ensure continuity of care as individuals transition from crisis situations to longer-term support.

STRUCTURE OF RECOMMENDATIONS

This section provides **recommendations for a place-based continuum of crisis services and settings**. These recommendations aim to address the immediate needs of an individual experiencing a crisis by facilitating their stabilization, ensuring access to appropriate clinical and supportive services, and diverting individuals from settings like emergency rooms and jails, which are not equipped or staffed to effectively manage behavioral health crises through a person-centered, recovery-oriented approach.

The recommendations are organized into two categories:

- 1) **“Under 24-Hour”** recommendations include **crisis receiving and stabilization centers** and other community-based models to address crisis in appropriate non-residential settings. Examples include **Sobering Centers, Behavioral Health Urgent Cares (BHUC)**, and peer-driven models such as **Living Rooms**.
- 2) **“Over-24 Hour”** recommendations address service model options for individuals requiring more than 24-hours – i.e., a residential setting – to achieve stabilization. Examples include **High-Intensity Extended Crisis Residential Centers (these facilities align to Alaska’s Subacute Facility Licensure requirements)**, **Moderate-Intensity Crisis Residential Centers, Residential Peer Crisis Respite**, and **Referral-Based Crisis Residential**.

This report offers recommendations on service models and implementation, including possible changes to Alaska’s Medicaid funding, administrative code, and provider guidance.

THE ROLE OF STAKEHOLDER INPUT AND FEEDBACK

Stakeholder feedback was instrumental in shaping all recommendations presented in this report, particularly regarding place-based stabilization. While behavioral health services have expanded under the 1115 Waiver and additional substance use disorder (SUD) providers are now included in Medicaid, Alaska still faces notable challenges in delivering place-based stabilization services. Stakeholder feedback identified key themes that informed these recommendations, incorporating perspectives from a diverse group of providers – serving mental health and SUD populations in outpatient and residential settings, youth and adult organizations, tribal providers, and local governments committed to improving crisis care systems.

Themes included:

- **Need for clarity on Alaska’s Subacute Facility Licensure regulations.** Providers noted that the proposed licensing requirements have affected access to place-based services and created a climate in which providers are hesitant to invest in facility-based stabilization services.
- **Need for flexibility in service models.** For some, flexibility means having options that align with their geographic location or population scarcity. Other providers expressed that workforce shortages make certain staffing requirements under the proposed Alaska Subacute Facility Licensing regulations prohibitive for sustaining needed services in their communities.
- **Need for collaboration across communities.** Providers stated that there is a need for greater collaboration across communities to share resources and access to appropriate levels of care and services through formal and informal provider to provider coordination of place-based settings.
- **Reliance on non-Medicaid funding.** Providers and advocates have largely relied on non-Medicaid funds to deliver crisis services in their communities due to a limited set of Medicaid reimbursed service options.

- **Disconnect between service standards and cost.** Providers and advocates noted that the service descriptions and rates for Crisis Stabilization Observation (COS) and Crisis Residential and Stabilization Services (CSS) do not align with the actual cost of delivering these services. Providers and advocates have consistently reported that the existing COS and CSS services present challenges because providers have been relying on two codes in an effort to develop a wide continuum of services.
- **Confusion around behavioral health and SUD distinction.** Providers reported confusion and frustration with how the 1115 Waiver bifurcates services between behavioral health and SUD. For crisis services, this division causes uncertainty in coding with V1 and V2 modifiers. Providers also raised concerns related to ensuring staff have appropriate Qualified Addiction Professional (QAP) designation – especially for behavioral health providers who serve individuals presenting with acute intoxication but may lack a qualifying mental health diagnosis.
- **Needs of rural and frontier communities.** Providers in rural and frontier areas of the state emphasized the need for stabilization service options that are adaptable to the specific needs of their communities, including the flexibility to use existing staff and program infrastructure to expand stabilization services.

Some of these concerns may be addressed in the short-term through finalization of Alaska's Subacute Facility Licensure regulations and guidance, while others will require thoughtful, longer-term solutions. DBH should evaluate and prioritize these recommendations and consider a phased approach to implementation of enhancements to the crisis continuum.

GENERAL PRINCIPLES AND RECOMMENDATIONS FOR THE PLACE-BASED CONTINUUM OF CARE

While the following recommendations focus on the third foundational element of the crisis continuum of care – *A Safe Place for Help* – stabilization services must operate in coordination and integration with other elements of the crisis response system. For place-based crisis services to be effective it is essential that these services are designed to operate within a crisis model that is easily accessible and trusted by the public and first responders, including law enforcement and emergency medical services (EMS).

As Alaska expands access to quality mobile crisis response around the state, it should establish clear accountability for adult and youth crisis response system coordination. Communities need service options and effective tools to manage crisis stabilization at regional and state levels to account for local gaps. Recommendations emphasize the necessity of expanded services alongside strong oversight structures to ensure integration and coordination.

Though beyond the scope of this project, Alaska may consider exploring financing structures that better maximize federal, state, and local funding streams, as well as administrative oversight models accountable for the overall coordination of the crisis continuum. Operating in a fee-for-service environment requires careful consideration for how to monitor and manage the crisis continuum utilizing actionable data and tools to coordinate between 988 call centers, mobile crisis response providers, and the network of place-based crisis stabilization providers.

Services should be designed, deployed, and coordinated as part of an integrated response system—not a discrete service—tailored to community needs. Services must match the population's size and density to ensure effective, timely care and foster trust. All crisis services should be designed, and the staff trained, with these considerations in mind:

- **Substance use and substance use disorders:** Crisis services should be designed to address both mental health and substance use needs for individuals in crisis, including those with co-occurring conditions. Staff must be trained to assess and intervene appropriately, considering the person's risk, needs, and preferences. Services should not exclude anyone based on substance-related or co-occurring issues, as long as it is safe to engage them. Providers should have clear protocols for managing intoxication, withdrawal, and making referrals to the appropriate level of care when necessary. All staff should receive

training and supervision to competently recognize, and address co-occurring mental health and substance use needs, ensuring comprehensive care for everyone in a behavioral health crisis.¹⁸

- **Crisis services should be person-centered, family-focused and provide the right level of care at the right time:** Crisis services should be person-centered, strength-based, and focused on resilience and recovery. Individuals, families, and supporters should help define what constitutes a crisis and when services are needed. Communities need a variety of crisis services for different levels of need, from emergency care for acute crises to less restrictive options for less severe cases, aiming to prevent unnecessary emergency department (ED) visits, hospitalizations, or justice system involvement.¹⁹
- **Crisis services should prioritize safety:** Crisis service settings must prioritize safety for individuals in crisis, staff, and the community by assessing and mitigating risks, fostering a welcoming and no-force-first culture, and minimizing physical and emotional harm. Services should be equipped to screen for and respond to a range of risks, including suicide, violence, medical complications, overdose, and interpersonal violence, and operate with strong protocols and evidence-based practices such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Collaborative safety planning, ongoing staff training, and the adoption of frameworks like Zero Suicide—which employs leadership, training, systematic risk assessment, timely care, evidence-based treatment, ongoing support, and continuous quality improvement. Crisis systems must also address overdose prevention, incorporate harm reduction principles, and ensure policies protect data privacy and individual rights.²⁰
- **Crisis services should be developmentally appropriate:** Crisis services for children, youth, and young adults should prioritize rapid, developmentally appropriate assessments, and minimize unnecessary exclusion or triage, with a focus on keeping children safely at home by engaging families and supporters in strong crisis safety plans. Staff must be trained in best practices for working with children, youth, and their families, recognizing that crisis events can be traumatic for all involved and that removal from the home should be a last resort.
- **Crisis services should be responsive to individuals' wholistic needs:** Crisis service providers must be equipped to address the needs of diverse populations. Services should be accessible to people with co-occurring medical conditions, physical disabilities, infectious diseases, and intellectual or developmental disabilities, brain injuries, or neurocognitive disorders. Providers should coordinate care with relevant agencies, offer reasonable accommodation, and ensure referrals to appropriate community and medical resources.

SERVICE MODEL RECOMMENDATIONS FOR CRISIS STABILIZATION SERVICES UNDER 24-HOURS

National guidance from SAMHSA calls for the delivery of crisis receiving and stabilization services in a 23-hour facility that operates 24/7/365 and accepts all referrals, such as walk-ins and first responder drop-off from law enforcement and emergency medical service providers. SAMHSA defines a no-barrier crisis service as crisis services that are accessible to any individual in need, regardless of circumstances, and without requirements that could delay or prevent care. The goal is to ensure immediate help for anyone experiencing a behavioral health crisis, without administrative or eligibility barriers.

For many Alaskan communities, reaching this standard is challenging. For some communities that are geographically isolated, low populations density may make a 24/7/365 high-acuity receiving facility with no-barrier access financially unsustainable due to uncertain demand for facility-based stabilization services. For other communities, the staffing requirements for a 23-hour facility capable of “no-barrier” access to stabilization, may be misaligned with the realities of staffing shortages for skilled clinical staff required for this model.

¹⁸ Substance Abuse and Mental Health Administration: 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. PEP24-01-037: Substance Abuse and Mental Health Services Administration, 2025.

<https://988crisisystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf>

¹⁹ *Ibid.*

²⁰ *Ibid.*

Not all communities can or need to offer no-barrier access to crisis stabilization services. As an alternative, low-barrier crisis services aim to reduce barriers as much as possible, although some minimal exclusionary requirements may exist due to staffing limitations or factors such as geography or population density.

Alaska's current crisis service array includes COS, reimbursed on an hourly basis, and CRS, reimbursed through a per diem rate. These service codes and service definitions were designed to provide flexibility to deliver crisis stabilization services in under 24-hour crisis receiving and stabilization centers and crisis residential services in over 24-hour crisis settings. These service definitions can be retired or phased out as service options are developed that offer a range of settings and clear guidelines for tiered rates based on service costs.

Tiered Crisis Receiving and Stabilization Services

Some states use tiered systems for crisis services when 23-hour centers are not feasible. These models let communities choose options that fit their needs, workforce, and budget. Tiered service structures allow quick responses to local needs and flexible coordination with nearby regions to improve access to care.

- **Missouri** serves as an example of a state that has adopted a tiered place-based service model for crisis receiving and stabilization centers. Missouri's Behavioral Health Crisis Centers (BHCC) model includes two types of BHCCs: centers with 24/7 operating hours and Urgent Care BHCCs with more limited hours. This structure is designed to address factors such as population density and workforce resources.²¹
- **Arizona's** crisis system includes both high-intensity and moderate-intensity crisis stabilization units. The high-intensity units are staffed with psychiatrists, nurses, and security, able to manage acute risk (e.g., suicide, aggression, severe intoxication). The moderate-intensity units are staffed with clinicians and peer support, focused on individuals with less acute needs and risks. Arizona's Medicaid and contracted managed care organizations reimburse at different rates depending on staffing levels, medical acuity, and required resources. High-intensity units receive higher per diem or hourly rates due to the need for more clinical oversight and security.²²
- **Texas** distinguishes between Crisis Stabilization Units (CSUs) and Crisis Respite Units (CRUs). While high-intensity CSUs provide locked and secured units, 24/7 clinical and medical staffing, and are able to manage severe behavioral health crisis including 3.7 level ASAM withdrawal management, moderate-intensity (CRU) services are provided in unlocked, less medically intensive staffing structures, and focused on support and observation for less acute individuals. The Texas tiered model reimburses CSUs at a higher rate than CRUs, reflecting the increased staffing, security, and medical resources needed.²³

It is recommended to develop a range of place-based stabilization services tailored to community needs and resource constraints, with clearly defined guidance on staffing, service delivery, and inclusion/exclusion criteria. Each service should have a payment rate and methodology aligned with these requirements to ensure sufficient resources for providing the required level of care.

Options for Under 24-Hour Stabilization Services

Currently, Alaska Medicaid offers only one reimbursement rate for observation and stabilization, regardless of the model, limiting providers' capacity to tailor services to community needs. Communities benefit from multiple service options as they set priorities, phase in complementary services, and improve their overall system of care. Rural and frontier communities gain flexibility and more immediate access through lower-intensity models such as Sobering Centers, BHUCs, and Living Room programs, even if they cannot support higher-intensity staffing.

Some states also designed place-based services to address specific needs beyond broad "no-barrier" 23-hour centers, allowing tailored solutions that better fit local resources, workforce, and populations.

21 Rules of Department of Mental Health: Division 3--Certification Standards, Chapter 7-Crisis Services, available at, Missouri Secretary of State: Code of State Regulations

22 NRI's 2023 State Profiles: State Support for 24-Hour Crisis Receiving & Stabilization Facilities, 2023, available at, [profiles-smha-support-for-crfsf-2023.pdf](#)

23 Texas Health and Human Services: Mental Health Crisis Services, available at <https://www.hhs.texas.gov/services/mental-health-substance-use/mental-health-crisis-services/crisis-units>

Creating new services or retiring existing services provides an opportunity for communities to develop a continuum of crisis stabilization services or provide one service level that best meets their unique community needs. The following services could be considered as part of an array of under 24-hour crisis stabilization services in the Alaska crisis continuum:

- 1) High-Intensity Sub-Acute Crisis Stabilization Center (aligns with Alaska's Subacute Facility Licensure requirements)
- 2) Moderate Intensity Crisis Stabilization Center
- 3) Behavioral Health Urgent Care
- 4) Sobering Center
- 5) Peer Living Room

Each service model is described below, with recommendations further detailed in [Appendix C](#). Multiple factors support providing an array crisis stabilization service options that are less than 24 hours in duration.

Currently, Alaska Medicaid offers only one reimbursement rate for observation and stabilization, regardless of the model, limiting providers' capacity to tailor services to community needs. Communities benefit from multiple service options as they set priorities, phase in complementary services, and improve their overall system of care. Rural and frontier communities gain flexibility and more immediate access through lower-intensity models such as Sobering Centers, BHUCs, and Living Room programs, even if they cannot support higher-intensity staffing.

Some states also designed place-based services to address specific needs beyond broad "no-barrier" 23-hour centers, allowing tailored solutions that better fit local resources, workforce, and populations.

1. High-Intensity Sub-Acute Crisis Stabilization Center.

The High Intensity Sub-Acute Crisis Stabilization Center service aligns with Alaska's Subacute Licensing regulations and serves two primary functions: ensuring **no barrier access** and facilitating **stabilization**. These centers accept all individuals, including those with unplanned or unscheduled arrivals, without requiring pre-screening or prior medical clearance. They offer immediate medical triage and ambulatory-level care for non-urgent medical conditions.

- **No Barrier Access:** These facilities operate continuously, receiving voluntary walk-ins and first responder drop-offs 24 hours a day, seven days a week. Employing a rapid intake process and adhering to a "no wrong door" policy, they assess and support every individual on site. If an individual requires services from another program or facility, they remain at the crisis center until appropriate referral or transfer arrangements are made.
- **Stabilization:** High-intensity centers provide emergency intervention for individuals experiencing behavioral health crises, including comprehensive triage and assessment. Typically, these stabilization services are initiated within 24 hours of entry. Following stabilization, individuals are either referred to an appropriate level of ongoing care or discharged to the community if clinically indicated.

Other distinguishing features of high-intensity crisis centers include:

- Does not require prior authorization
- Can receive individuals on voluntary or involuntary basis
- Have the regulatory, staffing, and environmental capacity for seclusion and restraints if necessary and are secure units
- Have access to a psychiatric provider with prescribing abilities 24/7/365

As the gold-standard for crisis receiving and stabilization services, the High-Intensity Sub-Acute Crisis Center provides the highest level of medical and psychiatric care for individuals experiencing a crisis and in need of urgent stabilization services. Details on specific model requirements, guidelines and staffing structures are provided in [Appendix C](#). This service is optimal for communities with high population density with predictable utilization patterns that support the need for a no-wrong door access point to crisis stabilization. Additionally, the capability of high-

intensity crisis centers to accommodate involuntary admissions allows for additional access for individuals pursuant to involuntary holds.

For many communities, however, this model is not sustainable due to the intensive on-site medical, psychiatric, and substance use disorder withdrawal capabilities – either due to low population density, limited resources, or workforce limitations.

2. Moderate Intensity Crisis Stabilization Center

Moderate-Intensity Crisis Centers are designed to provide behavioral health crisis care to individuals who **voluntarily** seek help and present with moderate acuity, distinguishing them from High-Intensity Centers that handle higher-risk or opt to provide involuntary admission. These centers focus on low-barrier access, accepting only voluntary admissions and generally managing individuals with less severe symptoms. While they offer a broad range of crisis services similar to High-Intensity Centers—including assessment, crisis counseling, medication management, withdrawal support, and care coordination—they typically lack onsite pharmacy or medication dispensing but maintain partnerships with local pharmacies for timely access to medications. Moderate-Intensity Centers do not use seclusion or physical restraints and are unable to serve those requiring involuntary holds or more intensive medical interventions. Services are delivered primarily in-person in a facility accredited for behavioral health care, with staff coverage 24/7, but at reduced ratios compared to higher-intensity settings. The centers emphasize individualized care, safety planning, family engagement, and coordinated discharge to appropriate follow-up care.

For most communities that face workforce constraints in meeting the requirements of a high-intensity center, this moderate-intensity crisis center model provides some flexibility in reducing required staffing levels of medical professionals. This includes a lower level of withdrawal management as well, requiring ASAM 3.2 WM rather than medically monitored ASAM 3.7 WM.

Other distinguishing features of a moderate-intensity crisis center are:

- Voluntary admissions only
- Lower acuity population: serves individuals with moderate, not severe, behavioral health crisis
- No seclusion or physical restraint
- Care coordination emphasis: strong focus on care coordination, community linkages, and follow-up, including peer support services

3. Behavioral Health Urgent Care

Behavioral Health Urgent Care (BHUC) centers provide a safe, voluntary, and timely alternative to hospital emergency departments and intensive crisis services for individuals experiencing a behavioral health crisis. BHUCs are low barrier, ambulatory (outpatient) settings, offering immediate, short-term, targeted interventions rather than ongoing behavioral health treatment. These centers are not intended for ongoing or longitudinal treatment.

BHUCs operate in ambulatory, outpatient settings—often as standalone clinics, but sometimes as adjuncts to hospitals, other crisis services, or in CCBHCs. They are characterized by extended operating hours, which can be up to 24/7/365, but provide flexibility to align access to peak days and hours of crisis needs in the community. Walk-in voluntary admissions are accepted, ensuring rapid, unscheduled access to care for anyone in need. However, individuals with medical needs beyond the BHUC's capacity or those at imminent risk of harm who cannot or will not engage in safety planning may be referred to a more appropriate level of care.

The service model for BHUCs is highly adaptable. The BHUC model emphasizes immediate, face-to-face assessment and stabilization, with services delivered primarily in person, though some specialty offerings may be available via telehealth. Core services include screening, triage, diagnostic assessment, clinical evaluation, crisis counseling, psychoeducation, and observation. BHUCs also provide physical health screening, point-of-care testing, and can initiate and administer medications – including medication for opioid or alcohol use disorders – in accordance with regulations.

An essential function of BHUCs is care coordination and linkage to further services. This is achieved through warm hand-offs, discharge planning, and follow-up to ensure individuals are connected to appropriate ongoing care, such as community-based services, support groups, or more intensive behavioral health programs. BHUCs should also address social determinants of health by connecting individuals with social services and supports as needed.

BHUCs are staffed by accredited and licensed providers, including psychiatrists or other prescribers (onsite or via telehealth), registered or licensed practical nurses, licensed behavioral health clinicians, and social services support staff.

BHUCs are an important service within the array of the crisis continuum. Many communities can create access through existing outpatient clinic services to voluntary crisis stabilization through extended hours of operation and coordination with community partners, health care providers, and first responders.

4. Sobering Center

Sobering centers are low-barrier, short-term (stays typically less than 24 hours), voluntary facilities operating 24/7/365, or can operate on reduced hours to align with community needs and staffing limitations. Sobering centers offer a supervised, supportive environment for adults experiencing acute intoxication from alcohol and/or other drugs. Their primary function is to allow individuals to safely recover from the immediate effect of intoxication, serving as a community-based alternative to jail or emergency departments. They are not designed to provide treatment, achieve abstinence, or manage medical withdrawal, but instead focus on harm reduction and stabilization, connecting clients to further care and resources as needed.

These centers offer open access with minimal eligibility requirements, accepting referrals from paramedics, law enforcement, EDs, clinics, community programs, or through self-referral and walk-in. Exclusion applies only to those with medical needs beyond the center's capacity or individuals requiring medically managed withdrawal services.

Sobering centers deliver non-medical monitoring and support in a safe, trauma-informed, and community-based environment distinct from medical or criminal justice settings. Individuals are assigned a mat, bed, or chair—usually in shared spaces rather than private rooms—and receive basic physical stabilization, oral rehydration, and food. Centers support self-administration of prescribed medications and monitor symptoms of intoxication and withdrawal according to established guidelines (e.g., ASAM levels). Services focus on client engagement, safety, and recovery planning, with a strong emphasis on harm reduction.

A key element of sobering centers is connecting individuals to appropriate community resources, medical care, recovery support, and social services. Centers coordinate care with existing providers and conduct warm hand-offs to ongoing services. Follow-up may occur in person, by phone, or virtually, and include outreach, engagement, risk reassessment, and support in implementing safety/crisis plans. Peer support is often offered in the follow-up process.

Staffing at sobering centers typically includes a minimum of two onsite staff at all times, with peer support providers and personnel holding at least EMT-basic certification. Staff are trained in de-escalation, crisis assessment, harm reduction, and culturally responsive care, but are not law enforcement or uniformed security. The environment is designed to be safe, supportive, and trauma-informed, with separate spaces for genders and private areas for clients as needed.

Staff competencies include active listening, rapport building, situational safety and risk assessment, crisis counseling and intervention, overdose prevention, and administration of opioid overdose reversal medications. Culturally responsive care and harm reduction approaches are central. Preferred practices include progressive engagement, motivational interviewing, community outreach, and co-location or close partnership with treatment services and social service providers.

As an example of a state that has integrated sobering centers into their crisis system, California has several counties operating Medicaid-funded sobering centers. In California, the California Advancing and Innovating Medi-Cal (CalAIM) 1115 Medicaid BH Demonstration Waiver allows for certain sobering center services to be billed as part of “enhanced case management” or “community supports” or have specific services such as assessment, care coordination, or brief intervention that are Medicaid reimbursable although direct reimbursement for supervision during sobering may be limited.

Similarly, Oregon's Medicaid program, through its network of Coordinated Care Organizations (CCOs), has supported the use of sobering centers. While the core sobering service (basic monitoring while intoxicated) may not always be directly reimbursed by Medicaid, associated services such as screening, referrals, and brief interventions provided in sobering centers can be billed to Medicaid. Some counties have successfully braided Medicaid and other funding sources to support their sobering centers.

5. Peer Living Room

Peer Living Room, or non-residential peer crisis respite services are voluntary, short-term, homelike settings that provide an alternative to hospitalization or emergency department use for individuals experiencing or at risk of a behavioral health crisis. These centers are operated and staffed by individuals with lived experience of mental health challenges (peer supporters), offering a supportive, person-centered environment grounded in mutuality, respect, and self-determination. This philosophy emphasizes empowerment, recovery, and the belief that individuals are the experts in their own lives.

Many states have incorporated **crisis respite and living room** services into their behavioral health crisis continuums, recognizing the need for flexible, community-based alternatives to hospitalization or law enforcement intervention. Living room services are typically short-term, voluntary, non-residential programs that offer safe, supportive environments for individuals experiencing a behavioral health crisis. States have developed various models of crisis respite care, often blending peer support, clinical oversight, and recovery-focused programming.

The strengths of a non-residential peer respite living room option for crisis stabilization include:

- **Diversion from Emergency Departments and Hospitals:** Crisis respite provides an alternative to higher-acuity, higher-cost settings, reducing unnecessary psychiatric hospitalizations and emergency room visits.
- **Person-Centered and Recovery Oriented:** These programs emphasize voluntary participation, autonomy, and peer support, which can foster engagement and empowerment for individuals in crisis.
- **Flexibility and Accessibility:** Respite services can be tailored to different populations, including adults, youth, or those with co-occurring disorders, and may be available in both residential and non-residential settings.
- **Cost-Effectiveness:** By offering lower-cost, community-based options, states can stretch limited behavioral health funding further and serve more individuals.

The limitations of the Crisis Respite Models, include:

- **Limited Acuity Range:** Crisis respite is generally appropriate for individuals who do not require intensive medical psychiatric intervention and may not be able to safely serve those at imminent risk of harm to self or others.
- **Workforce Challenges:** Staffing respite programs, especially with peers and clinicians, can be difficult in rural or underserved areas due to workforce shortages or lack of specialized training.
- **Geographic Access:** In sparsely populated or rural regions, the availability of crisis respite may be limited, requiring creative solutions like mobile teams, telehealth, or partnerships with local organizations.
- **Sustainability and Funding:** Reliance on grant funding or patchwork financing can threaten the long-term sustainability of crisis respite programs, particularly in states without Medicaid reimbursement for these services.

Crisis respite is particularly valuable in communities where hospital beds are scarce, stigma prevents individuals from seeking help in traditional settings, or where law enforcement is the default crisis responder. By offering a welcoming, non-institutional environment, respite services can reach individuals who might otherwise avoid or delay care. In areas with workforce limitations, some states have developed peer-run respite centers, leveraging the lived experience of staff as a unique asset, while others use telehealth to provide clinical oversight and direct clinical services remotely.

Texas, for example, provides a **crisis respite** service for non-medical, voluntary support for individuals with low acuity. These additional low-acuity and voluntary services allow communities to meet a significant need for crisis support services without requiring no-barrier or low-barrier models that may be financially unsustainable or are not well tailored to the needs of the population that they serve.

New York operates both residential crisis respite centers and peer-run, non-residential respite programs. Non-residential models may include drop-in centers or day programs where individuals can access support, rest, and crisis counseling without overnight stays. NYC's Parachute NYC Peer Respite Centers offer voluntary stays up to 7 days, with an emphasis on recovery and self-direction. Their non-residential drop-in services allow for brief crisis support, helping to prevent escalation and hospitalization.

OPTIONS FOR OVER 24-HOUR STABILIZATION SERVICES

Currently, Alaska's single crisis residential rate is not tied to a particular service model, limiting providers' ability to meet community needs and resource limitations. As with under 24-hour stabilization services, some areas benefit from multiple options for phased planning, while rural regions may need adaptable models for faster access. Even where high-intensity staffing is not possible, low-barrier options like Peer Crisis Residential Respite or referral-based services can improve access to stabilization support.

The following services could be added to the array of over 24-hour crisis stabilization services in the Alaska crisis continuum:

- 1) High-Intensity Sub-Acute Extended Crisis Residential (aligns with Alaska's Subacute Facility Licensure requirements)
- 2) Moderate-Intensity Extended Crisis Residential
- 3) Peer Crisis Residential Respite
- 4) Crisis Residential (referral-based)

Each service model is described below, and supporting recommendations for the development of service definitions, requirements, and guidance are provided in further detail in [Appendix D](#).

1. High-Intensity Sub-Acute Extended Crisis Residential

High-Intensity Sub-Acute Behavioral Health Extended Stabilization Centers are specialized facilities designed to offer emergency behavioral health care beyond the initial 24-hour crisis period. Often co-located with High-Intensity Sub Acute Crisis Centers, these extensions provide a safe, supportive environment with individual private rooms and beds, typically for 3–5 days, with the option of accommodating both voluntary and involuntary admissions. Their primary aim is to stabilize individuals in crisis, manage withdrawal symptoms, and prepare them for transition back to the community or to another level of care. This service aligns with Alaska's Subacute Facility Licensure requirements.

Key features include private rooms with beds (not recliners), flexible length of stay (no strict limit), and acceptance of involuntary admissions based on local regulations and provider option. They are equipped for 24/7 care, including the capacity for seclusion and restraint if necessary, and adhere to standards equivalent to behavioral health inpatient units.

This model emphasizes ongoing care coordination, family engagement, and addressing psychosocial stressors and social determinants of health (SDOH). Follow-up is provided in-person, by phone, or virtually, including risk reassessment, crisis/safety plan updates, and active peer involvement. Eligibility extends to individuals transitioning from High-Intensity Sub-Acute Crisis Centers or admitted directly from the community or other providers. Exclusions apply to those needing higher-level medical intervention than the center can provide.

This model ensures individuals experiencing behavioral health emergencies receive intensive, person-centered care that bridges the gap between crisis and community reintegration and continued support and treatment.

In some states, extended crisis residential units operate to ensure capacity in the 23-hour crisis centers, allowing for a transition to longer residential care for individuals who require longer periods for stabilization and placement with an appropriate level of care in the community.

An advantage of this service model is that when co-located with a high-intensity sub-acute crisis center, staffing may be shared between units as long as each unit retains required staffing levels. This can alleviate some staffing pressures during periods of low utilization. Current requirements for sharing staff between co-located facilities is addressed in Alaska's Subacute Facility Licensure requirements.

2. Moderate-Intensity Extended Crisis Residential

Moderate-Intensity Behavioral Health Extended Stabilization Centers are designed to provide voluntary, short-term (typically 3–5 days) behavioral health crisis care beyond the initial 23-hour period. These centers offer private rooms with beds, extended stabilization, and moderate withdrawal management, serving as a bridge to the next appropriate level of treatment or support. They are often co-located with Moderate-Intensity Centers and focus exclusively on voluntary admissions.

Key features include dedicated private rooms with beds, a flexible length of stay, and services exclusively for voluntary individuals. These centers do not handle involuntary admissions and are prepared to provide meal services tailored to dietary needs. Services largely parallel those of moderate-intensity crisis centers and include:

- Comprehensive assessments (screening, triage, diagnostic, bio-psychosocial)
- Crisis counseling and psychoeducation
- Medication initiation and administration
- Management of intoxication/withdrawal symptoms (MOUD and MAUD)
- Safety and recovery planning
- Care coordination and family/caregiver engagement
- Assistance with psychosocial stressors and social determinants of health (SDOH)
- Support for physical health issues at the ambulatory level
- Discharge planning with warm hand-offs and community referrals

Emphasis is placed on linking individuals to established providers and community resources, providing warm hand-offs, and offering follow-up through various modalities (in-person, phone, virtual). Peer support workers and specialists are engaged in follow-up contacts, ensuring continuity and ongoing engagement. There are no strict eligibility criteria aside from voluntary status. Exclusionary criteria include involuntary admissions, medical needs beyond ambulatory care, or acute behavioral health conditions requiring a more intensive environment.

3. Peer Crisis Residential Respite

Peer Crisis Residential Respite centers are voluntary, short-term, homelike settings that provide an alternative to hospitalization or emergency department use for individuals experiencing or at risk of a behavioral health crisis. These centers are operated and staffed by individuals with lived experience of behavioral health challenges (peer support), offering a supportive, person-centered environment grounded in mutuality, respect, and self-determination. This philosophy emphasizes empowerment, recovery, and the belief that individuals are the experts in their own lives.

Peer Crisis Residential Respite is designed to be low-barrier and voluntary, with minimal eligibility criteria. Individuals can self-refer or be referred by community providers, EMS, law enforcement, family, or friends. There are generally no exclusionary criteria based on diagnosis, insurance status, or ability to pay, though some centers may have limitations related to safety, such as the inability to support individuals with acute medical needs or those at imminent risk of harm to self or others.

The service model is based on peer support and non-clinical approaches. The environment is intentionally non-institutional, comfortable, and homelike to foster a sense of safety, dignity, and autonomy. Stays are typically short-term (often 1–7 days), and the focus is on providing emotional support, crisis intervention, and the opportunity for rest and reflection. Guests are encouraged to set their own goals and participate in shared decision-making about their stay and support needs.

Core services include peer-to-peer support, crisis de-escalation, wellness planning, and connection to community resources. Staff use their own lived experience to build trust, model recovery, and offer hope. Services are flexible and individualized, ranging from one-on-one support to group activities. Peer crisis respite centers may also assist with care coordination and referrals to ongoing mental health, recovery, or social services as desired by the guest.

Staffing consists primarily of trained peer support specialists who have personal experience with mental health or substance use recovery. Competencies include active listening, trauma-informed care, cultural humility, crisis intervention, de-escalation, harm reduction, and knowledge of community resources. Staff are not clinical providers, and the model does not include routine medical or psychiatric care. Programs can, however, provide access to licensed behavioral health professionals to complete assessments and provide crisis intervention services if needed.

Care coordination is collaborative and guest-directed, focusing on linking individuals to community-based supports, resources, and services that align with their goals. Discharge planning is a shared process, with an emphasis on safety, wellness, and ongoing support. Follow-up contact may be offered after the stay to reinforce connections and maintain engagement.

4. Crisis Residential (referral-based)

Referral-Based Crisis Residential Facilities provide voluntary, short-term residential care. These models can be adapted to provide moderate- or low-intensity service environments and therefore offer communities a pathway to provide residential crisis services in relation to community need and resource barriers. This service model is distinguished from the extended residential crisis centers which are often co-located with short-term crisis stabilization centers and act as receiving centers. These settings are not equipped to be receiving centers; however, they can closely coordinate access through defined referral pathways to community partners, individuals self-referring, other crisis settings, and police and EMS.

- **Low-Intensity Crisis Residential Facilities** provide voluntary, short-term residential care with less intensive medical monitoring and lower staffing ratios than moderate-intensity programs. The focus is on connecting individuals to community resources and supporting crisis resolution in a staff-secured (but not locked) setting. They offer withdrawal management for mild symptoms.
- **Moderate-Intensity Crisis Residential Facilities** offer non-hospital, short-term (typically a few days to two weeks) residential care for individuals experiencing behavioral health crises. These programs provide 24/7 monitoring, psychiatric and nursing services, and intensive support, often in secured, stand-alone settings. They can serve voluntary admissions and provide withdrawal management for mild to moderate symptoms.

A referral-based crisis residential service also allows for possible flexibilities in staffing to allow communities to provide variable levels of access based on acuity of an individual's needs. Low-intensity referral-based crisis residential services can be developed to allow for staffing models that may be sustainable in rural and frontier communities. For example, staffing for a low-intensity setting may only require one crisis worker to be on site 24/7/365, while only requiring a psychiatrist or prescriber to make onsite visits, but not requiring 24/7/365 access to a prescriber. Other professional staffing can be flexible to ensure that either nursing or EMT providers are onsite with additional supports from licensed behavioral health staff.

RECOMMENDATIONS AND CONSIDERATIONS FOR IMPLEMENTATION PLANNING

To implement the new service continuum for place-based stabilization services, potential required changes and considerations related to service authority, billing codes, service descriptions, and guidance include:

Updates to COS and CSS services: DBH may consider revising existing service definitions for place-based stabilization services, including phasing out current billing codes for COS and CSS. These codes and rates do not reflect differences in service models, staffing, or acuity levels within under-23-hour services and crisis residential facilities.

Additionally, to the extent that the Short-Term Crisis Intervention service in the Medicaid State Plan is seen as equivalent or similar to the COS service in the 1115 Waiver, providers are incentivized to use Short-Term Crisis

Intervention given the reimbursement rate is 21% higher than that of COS, \$152.94 compared to \$126.89 for each one-hour unit.^{24,25}

Rate review: Providers consistently reported that current reimbursement rates do not reflect the costs associated with delivering services. The forthcoming DOH rate study presents an important opportunity to better align reimbursement rates with actual service delivery expenses.

During the rate study, it is important for DOH to comprehensively evaluate all costs related to new and updated service standards and integrate them into the overall cost analysis. This is particularly critical in the context of staffing structures and hours of operation for each service. In response, DBH could implement **tiered rates for place-based stabilization services** to reflect the following areas:

- **Acuity-Based Reimbursement:** States use acuity scoring tools to classify patients and facilities. Higher-acuity facilities get higher rates due to greater resource needs.
- **Cost Modeling:** States may require annual cost reports from providers, factoring in staffing, facility, security, and clinical resources.
- **Service Intensity:** Rates should reflect the intensity of services provided, including frequency of clinical assessment, medication management, and physical security.
- **Length of Stay:** Rates may be structured as per diem, per hour, or per encounter depending on the nature of service delivery in different service models and settings.

Implementation Authority: Federal Medicaid regulations impose limits on the coverage of services delivered in residential settings. Under the Institution for Mental Diseases (IMD) exclusion, Medicaid is generally prohibited from covering services provided to adults in facilities with more than 16 beds when the length of stay exceeds 24 hours. While states have flexibility under the state plan to define and cover crisis stabilization services, the State Plan alone cannot authorize coverage of residential crisis services for adults that extend beyond the 24-hour threshold in IMD settings.

Based on this framework, Alaska could pursue a SPA to authorize the proposed under 24-hour stabilization services. However, to authorize crisis stabilization services exceeding 24 hours, the state would likely need to seek approval under 1115 demonstration waiver authority to ensure compliance with federal IMD requirements.

Finally, to phase out the current COS and CSS services, the state would need to amend its existing 1115 Waiver to remove those services and ensure the waiver continues to align with the state's crisis services continuum. DBH would need to seek amendment approval for the changes to the service specifications and payment methodology under the chosen federal pathway authorizing the service (state plan or 1115 Waiver) and update the relevant sections of Alaska Administrative Code.

Discontinue the use of V1/V2 modifiers for under 24-hour crisis stabilization services: Current billing guidance under the 1115 waiver requires a V1 modifier for SUD-related crises and a V2 modifier for BH-related crises. Stakeholders noted it is challenging to identify the cause during a crisis since individuals often have both SUD and mental health symptoms, making accurate modifier selection difficult and inconsistent with real-life situations. Alternatively, Alaska could allow the use of both modifiers on a claim so that providers are not required to decide at the time of a crisis event.

Discontinue the required use of V1/V2 modifiers for over-24-hour crisis residential based services: For extended residential stabilization services, providers may be better positioned to assess the underlying conditions and diagnosis of the individual in crisis, however, stakeholders uniformly agreed that often there are complex co-occurring conditions that do not easily align with these distinctions.

²⁴ State of Alaska, Department of Health, Division of Behavioral Health. Chart of Community Behavioral Health and Mental Health Physician Clinic Medicaid Covered Service Rates. (July 1, 2025) <https://health.alaska.gov/media/naghxmqj/sfy26-community-behavioral-health-and-mental-health-physician-clinics-v4.pdf>

²⁵ State of Alaska, Department of Health, Division of Behavioral Health. Chart of Behavioral Health Reform 1115 Medicaid Service Rates. (November 8, 2024). <https://health.alaska.gov/media/5dwg0tma/chart-of-behavioral-health-reform-1115-medicare-services-rates-effective-2024-11-08-1.pdf>

Review QAP requirements for crisis services under the 1115 Waiver: Alaska's QAP designation aims to ensure providers receive necessary education and training to deliver quality SUD services to Medicaid recipients. However, these requirements can be confusing, especially in the crisis stabilization context. Providers expressed concern because individuals working in crisis settings often engage with individuals with complex conditions and often do not know the underlying diagnosis of the individual in crisis. Crisis services should prioritize person-centered, recovery-focused care, regardless of diagnosis. While QAP ensures workforce training for individuals in SUD provider settings, all crisis workers, including those providing call center, mobile crisis, and place-based services, —should be trained to address both mental health and substance use disorder needs.

DBH could develop standards for provider qualifications, training, and continuing education. This would ensure all providers receive consistent, focused training on crisis care, integrating behavioral health, SUD, and other key population needs across various crisis settings.

Develop consistent training, certification, and continuing education framework for all crisis workers across the continuum of crisis services. Recognizing that the underlying causes of a behavioral health crisis are multi-faceted and complex, all provider staff engaged in the delivery of crisis continuum care should receive consistent training and continuing education to ensure competency to provide crisis services utilizing best practices and increasing staff's understanding of the interconnected systems of care that are involved in addressing crisis situations and appropriately supporting individuals to ongoing services and resource. Additionally, due to the bifurcation of behavioral health and SUD services in Alaska, it is essential that all crisis workers have competence in working with individuals with mental health and substance use disorders and knowledge of both systems of care in Alaska.

Conclusion

The development of Alaska's behavioral health crisis continuum is an important step toward ensuring more timely, equitable, and effective care for people facing mental health and substance use challenges. Through targeted revisions to service standards, strategic rate adjustments, and long-term planning for mobile crisis response and place-based stabilization, DBH is laying the foundation for a more responsive and sustainable system.

This approach considers the unique challenges that many Alaskan communities face, such as geographic challenges, workforce shortages, and varying population sizes. By focusing on models that can be tailored to local needs and realities, Alaska is seeking solutions that make quality crisis care accessible in all communities. DBH's commitment to using national best practices, along with continuous feedback from stakeholders, helps ensure the new system is practical, effective, and responsive to those who need it most.

Appendix A. Overview of Engagement with Interested Parties

FIGURE 3: INTERESTED PARTIES

Date	Service/Topic	Organization	Name
April 21, 2025	Place-Based Stabilization	Alaska Behavioral Health (AKBH)	▪ Jim Myers
		JAMHI Health & Wellness	▪ Emory Welch
		Mat-Su Behavioral Health	▪ Siobhan Cunningham
		Mat-Su Crisis Now	▪ Melissa Toffolon
		Mayor's Office, Municipality of Anchorage	▪ Thea Agnew Bemben
		Northern Hope Center	▪ Karen Blackburn
		Volunteers of America (VOA) Alaska	▪ Jamie Elkhill
April 23, 2025	Mobile Crisis Response	Agnew::Beck Consulting	▪ Megan Carlson
		Alaska Behavioral Health (AKBH)	▪ Brighton Brooks ▪ Courtney Evans ▪ Jim Myers
		Anchorage Fire Department	▪ Jennifer Pierce
		City of Fairbanks	▪ Brenda McFarlane
		Mat-Su Behavioral Health	▪ Siobhan Cunningham
		Mat-Su Crisis Now	▪ Melissa Toffolon
		Northern Hope Center	▪ Karen Blackburn
		True North Recovery	▪ Josh Engle
May 12, 2025	Mobile Crisis Response	Agnew::Beck Consulting	▪ Becky Bitzer
		Anchorage Fire Department	▪ Jennifer Pierce
		Central Peninsula Hospital Behavioral Health Department	▪ Sofia Costales
		City of Fairbanks	▪ Brenda McFarlane
		True North Recovery	▪ Chloe Sylvester ▪ Josh Engle
May 21, 2025	Place-Based Stabilization	Set Free Alaska, Inc.	▪ Bev Ray ▪ Phillip Licht ▪ Sean Gilbert
May 21, 2025	Place-Based Stabilization	Yukon-Kuskokwim Health Corporation (YKHC)	▪ Claire Ramos
May 21, 2025	Place-Based Stabilization	Residential Youth Care (RYC)	▪ Dustin Larna
May 27, 2025	Place-Based Stabilization	True North Recovery	▪ Chloe Sylvester

Date	Service/Topic	Organization	Name
			▪ Karl Soderstrom
May 27, 2025	Place-Based Stabilization	Alaska Behavioral Health (AKBH)	▪ Jim Myers
August 5, 2025	Mobile Crisis Response	Alaska Behavioral Health (AKBH)	▪ Courtney Evans
		Anchorage Fire Department	▪ Jennifer Pierce
		Anchorage Health Department	▪ Kimberly Rash
		City of Fairbanks	▪ Brenda McFarlane
		Yukon-Kuskokwim Health Corporation (YKHC)	▪ Adrienne Gregory
August 12, 2025	Place-Based Stabilization	Alaska Native Tribal Health Consortium (ANTHC)	▪ Gennifer Moreau
		Family Centered Services of Alaska (FCSA)	▪ Carl Leake
		Set Free Alaska, Inc.	▪ Bev Ray ▪ Amanda Zeppa
		True North Recovery	▪ Josh Engle

Appendix B. MOCR Service Definition Revisions for the Short-Term

On August 5, 2025, Milliman and DBH brought together a focus group with providers and key stakeholders to review the proposed updates to the Mobile Outreach and Crisis Response (MOCR) and MOCR Follow-Up service standards. The table below outlines the revised language under consideration. Where participants in the focus group offered substantive feedback, these comments have been noted in *green italicized text* for DBH's further review.

FIGURE 4. MOCR SERVICE DEFINITION REVISIONS

Service Name (Abbreviation)	Mobile Outreach and Crisis Response Services (MOCR)	Proposed Updated Language
Authority Effective Date Revision History	7 AAC 138.450 (BH) / 7 AAC 139.350 (SUD) Effective {effective date of regulations} Revision 05/21/2020 Revision 08/04/2020 Revision 12/15/2022 Revision 10/9/2023	No changes
Service Description	MOCR services are provided to prevent a mental health crisis or to stabilize an individual during or after a mental health crisis. Services are available 24/7 to individuals and/or families who are experiencing a crisis or have received a MOCR service within 48 hours. MOCR services are delivered in the community in any location where the provider and the individual can maintain safety. MOCR services render rapid assessment and intervention, prevent crises from escalating, stabilize the individual/family, and connect the individual/family to appropriate services needed to resolve the crisis with essential follow up to ensure connection to resources and/or ensure the crisis has stabilized.	MOCR services are provided to: (1) Prevent a substance use disorder or mental health crisis from escalating; (2) Stabilize an individual during or after a mental health crisis or a crisis involving a substance use disorder; or (3) Refer and connect an individual to other appropriate services that may be needed to resolve the crisis. MOCR services render rapid assessment and intervention, prevent crises from escalating, stabilize the individual/family, and connect the individual/family to appropriate services needed to resolve the crisis with essential follow-up to ensure connection to resources and/or ensure the crisis has stabilized.
Service Components	• Triage and screening, including screening for suicidality • Crisis assessment including causes leading to the crisis, safety and risk considerations, strengths and resources, recent behavioral health treatment, medications prescribed and recent compliance, and medical history as it relates to the crisis • Peer support as part of the MOCR team	No changes

Service Name (Abbreviation)	Mobile Outreach and Crisis Response Services (MOCR)	Proposed Updated Language
	• Crisis planning included, such as the creation of a safety plan • Coordination, referral and linkage with appropriate community services and resources • Linkage to medication services as indicated • Skills training designed to minimize future crisis situations	
Contraindicated Services	None	No changes
Service Requirements	MOCR programs must be available 24 hours a day, 7 days of the week, make available psychiatric consultation, and provide rapid face-to-face response as follows: • The person in crisis must be present for a majority of the service delivery duration. • Urban teams on average must respond to individuals within an hour. • Rural and frontier teams are not required to respond within an hour but must document efforts taken with respect to a rapid face-to-face response. For an initial individual crisis request, a MOCR program must ensure that a team of at least two staff respond, face-to-face, including a mental health professional clinician and a qualified behavioral health provider, such as a behavioral health associate. • Rural and frontier programs may have only one staff person onsite to respond and may use telehealth to meet the requirement for at least one additional qualified staff (or more as needed). MOCR programs must document attempt to crisis follow-up with an individual after a response within 48 hours to ensure support, safety, and confirm linkage with any referrals. This requirement may be satisfied through a phone call or a telehealth engagement with an individual.	Hours of operation: MOCR teams should be available to provide mobile crisis response services 24 hours a day, 7 days a week, every day of the year. If an organization has not yet reached full 24/7 coverage, it should provide the widest possible service window while working toward that standard – aligned with community needs. Whatever hours are offered must be consistent and clearly communicated so the public can rely on timely access to care. Each MOCR program is asked to provide its operating hours to DBH and provide written notice to DBH of any subsequent changes. See Service Code for modifiers indicating whether the response was provided by an MOCR program providing 24/7 service delivery or less than 24/7 service delivery. MOCR team composition: For an initial crisis response, the MOCR program must ensure that a team of at least 2 staff provide a face-to-face response. The team must include at least one licensed <i>clinician</i> and one unlicensed/certified <i>peer/paraprofessional</i>, such as a behavioral health aide. Rural and frontier teams are permitted to have only one staff member onsite to respond and may use telehealth to meet the requirement for at least one additional qualified staff (or more as needed). The 2-person response requirement can be met if the composition of the team providing the response reflects one of the below options:

Service Name (Abbreviation)	Mobile Outreach and Crisis Response Services (MOCR)	Proposed Updated Language
	MOCR programs must coordinate with law enforcement and a 23-hour crisis observation and stabilization (COS) services and crisis stabilization services, when available. When appropriate, MOCR services may also be provided to the family or support system in support of an individual who is experiencing a behavioral health crisis.	• 1 licensed clinician and 1 unlicensed/certified peer/paraprofessional • 2 licensed clinicians • 2 unlicensed/certified peer/paraprofessional (with telehealth access to an on-call licensed clinician) • 1 licensed clinician OR 1 unlicensed/certified peer/paraprofessional (with telehealth access to an on-call licensed clinician) – Rural/frontier only See <u>Staff Qualifications</u> for further information relevant to staffing and team composition. See <u>Service Code</u> and <u>Additional Information</u> for billing guidance relating to team composition. Stakeholder feedback: <i>Focus group participants noted that permitting a single-person response offers valuable flexibility. However, some expressed concerns regarding safety. As such, they suggested it may be prudent to ensure that a Crisis Intervention Team (CIT) trained officer is available as backup, or to arrange for meetings to take place at clinics where additional staff are present.</i> Response time: Urban teams, on average, must respond within one hour. Rural and frontier teams are exempt from the one-hour requirement; however, they must document actions to provide face-to-face contact. Follow-up services: MOCR programs must document attempt to follow-up with an individual within 48 hours after the initial crisis response. See <i>MOCR Follow-Up</i> for service standards and administrative procedures related to services and support provided after the initial response. Coordination: MOCR programs should coordinate with local crisis lines as part of their dispatch processes, including but not limited to 911/EMS, 988, and/or other regional crisis lines.

Service Name (Abbreviation)	Mobile Outreach and Crisis Response Services (MOCR)	Proposed Updated Language
		Stakeholder feedback: Focus group participants preferred the wording should coordinate with local crisis lines over must, noting that coordination with 911/EMS could be logistically difficult and these systems may need separation. Some providers, in survey responses, said such coordination already occurs through referrals and calls from 911/EMS, though this was not discussed in the August 5 focus group. MOCR programs must coordinate with law enforcement and an entity providing 23-hour crisis observation services (COS) or other crisis stabilization services, when available.
Target Population	MOCR services are provided to (1) prevent substance use disorder or mental health crisis from escalating; (2) stabilize an individual during or after a mental health crisis or a crisis involving a substance use disorder; or (3) refer and connect an individual to other appropriate services that may be needed to resolve the crisis. MOCR team may work with immediately family, kinship relation, or non-kinship primary caregiver and child (when the service recipient is a minor) to reduce or deescalate the identified behavior. MOCR teams may work with immediately family, kinship relation, or non-kinship primary caregiver and child for the follow-up interaction to the initial face-to-face contact.	MOCR services are available to anyone who perceives themselves to be in a mental health and/or substance use-related crisis; the individual seeking help determines what constitutes a crisis. Additionally, the MOCR team may work with immediate, family, kinship or non-kinship primary caregiver and child (when service recipient is a minor) to reduce or de-escalate the identified behavior.
Staff Qualifications	MOCR services may be staffed by a multidisciplinary team of qualified professionals. Providers qualified to be reimbursed for eligible services include: • Licensed Physicians • Licensed Physician Assistants • Advanced Practice Registered Nurses • Licensed Registered Nurses • Licensed Practical Nurses • Mental Health Professional Clinicians • Substance Use Disorder Counselors	Please see the above <i>Service Requirements</i> for more information and guidance regarding MOCR team composition.

Service Name (Abbreviation)	Mobile Outreach and Crisis Response Services (MOCR)	Proposed Updated Language
	• Certified Medical Assistants/Certified Nursing Assistants • Community Health Aides • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialists	
Service Location	MOCR services may be provided in any location where the provider and the individual can maintain safety. 02 - Telehealth, patient not located at home 03 – School 04 - Homeless Shelter 05 - Indian Health Service Free-standing Facility 06 - Indian Health Service Provider-based Facility 07- Tribal 638 Free-standing Facility 08 - Tribal 638 Provider-based Facility 10 – Telehealth, patient located at home 11 – Office 12 - Home 13 - Assisted Living Facility 14 - Group Home 15 - Mobile Unit 16 - Temporary Lodging 18 - Place of employment 19 - Off Campus Outpatient Hospital 20 - Urgent Care Facility 21 - Inpatient Hospital 22 - On Campus Outpatient Hospital	No suggested changes

Service Name (Abbreviation)	Mobile Outreach and Crisis Response Services (MOCR)	Proposed Updated Language
	23 - Emergency Room 26 - Military Treatment Center 34 - Hospice 49 - Independent Clinic 50 - Federally Qualified Health Center 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility- Partial Hospitalization 53 - Community Mental Health Center 54 - Intermediate Care Facility/Individuals with Intellectual Disabilities 55 - Residential Substance Abuse Treatment Facility 56 - Psychiatric Residential Treatment Center 57 - Non-Residential Substance Abuse Treatment Center 58 - Non-Residential Opioid Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility 71 - State or local Public Health Clinic 72 - Rural Health Clinic 99 - Other appropriate place of service If the service is provided via telehealth, then the appropriate telehealth modifier must be appended.	
Service Frequency/ Limits	None	No suggested changes
Service Authorization	No service authorization required	No suggested changes
Service Documentation	Must be documented in a progress note in accordance with 7 AAC 139.350.	No suggested changes

Service Name (Abbreviation)	Mobile Outreach and Crisis Response Services (MOCR)	Proposed Updated Language		
Relationship to Other Services	MOCR services may be provided concurrently with any service listed in standards manual that is not otherwise contraindicated.	No suggested changes		
Service Code	T2034 V1 (SUD) T2034 V2 (BH)	T2034		
		BH/SUD	X1	BH (mental health)
			X2	SUD
		Team composition	Y1	Clinician + peer/para; OR 2 Clinicians
			Y2	2 peers/para (telehealth access to on-call clinician)
			Y3	1 clinician/peer/para (telehealth access to on-call clinician)
		Program's hours of service delivery	Z1	24/7 every day of the year
			Z2	Less than 24/7 every day of the year
Unit Value	1 unit = Per Call Out	No changes		
Payment Rate	See rate chart.	Pending rate review		
Additional Information	Programs may employ a multidisciplinary team of professionals to perform MOCR; however, each unit of service must be provided by a mental health professional clinician or other qualified professional listed in staff qualifications to be eligible to draw down the per unit rate. Qualified providers of MOCR services are recommended to follow the SAMHSA "Essential Principles for Modern Crisis Care Systems" from the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit Executive Summary. (Attachment A)	Programs must utilize a multidisciplinary team of professionals to conduct MOCR. However, each service unit must be delivered by a team that aligns with one of the team composition options outlined in the <u><i>Service Requirements</i></u>. It is recommended that qualified providers of MOCR services adhere to the most recent version of SAMHSA's <i>National Guidelines for a Behavioral Health Coordinated System of Crisis Care</i>. (Attachment A) Available online: https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care		

Service Name (Abbreviation)	Mobile Outreach and Crisis Response Services (MOCR)	Proposed Updated Language
	https://www.samhsa.gov/sites/default/files/national-guidelines-forbehavioral-health-crisis-services-executive-summary-02242020.pdf	

FIGURE 5. MOCR FOLLOW-UP SERVICE DEFINITION REVISIONS

Service Name (Abbreviation)	MOCR Crisis Service Follow Up	Proposed Updated Language
Authority Effective Date Revision History	7 AAC 139.350 (SUD) / 7 AAC 138.450 (BH) Effective {effective date of regulations} Revision 12/15/2022 Revision 10/9/2023	No changes
Service Description	MOCR services are provided to prevent a mental health crisis or to stabilize an individual during or after a mental health crisis. Services are available 24/7 to individuals and/or families who are experiencing a crisis or have received a MOCR service within 48 hours. MOCR services are delivered in the community in any location where the provider and the individual can maintain safety. MOCR services render rapid assessment and intervention, prevent crises from escalating, stabilize the individual/family, and connect the individual/family to appropriate services needed to resolve the crisis with essential follow up to ensure connection to resources and/or ensure the crisis has stabilized. MOCR crisis services follow up are provided to individuals and/or families to ensure connection to resources and/or ensure the crisis has stabilized. The follow up continues to assess for safety and confirms linkage with any referrals.	MOCR Follow-Up services are provided to individuals and/or families who have experienced a behavioral health crisis within the last 48 hours. The service is intended to ensure individuals and/or families have a connection to resources and/or ensure the crisis has stabilized. The follow-up response service continues to assess and confirms linkage with any referrals.
Service Components	• Triage and screening, including screening for suicidality • Crisis assessment including causes leading to the crisis, safety and risk considerations, strengths and resources, recent behavioral health treatment, medications prescribed and recent compliance, and medical history as it relates to the crisis • Peer support as part of the MOCR team • Crisis planning included, such as the creation of a safety plan • Coordination, referral and linkage with appropriate community services and resources • Linkage to medication services as indicated • Skills training designed to minimize future crisis situations	No suggested changes

Service Name (Abbreviation)	MOCR Crisis Service Follow Up	Proposed Updated Language
Contraindicated Services	None	No suggested changes
Service Requirements	MOCR programs must document attempt to crisis follow-up with an individual after a response within 48 hours to ensure support, safety, and confirm linkage with any referrals. This requirement may be satisfied through a phone call or a telehealth engagement with an individual.	MOCR programs must document attempts to follow up with an individual within 48 hours to ensure support, safety, and confirm linkage. This requirement can be fulfilled through a phone call or a telehealth engagement conducted by either a licensed clinician or a peer/paraprofessional, as appropriate for the individual's needs.
Target Population	MOCR services are provided to (1) prevent substance use disorder or mental health crisis from escalating; (2) stabilize an individual during or after a mental health crisis or a crisis involving a substance use disorder; or (3) refer and connect an individual to other appropriate services that may be needed to resolve the crisis. MOCR team may work with immediately family, kinship relation, or non-kinship primary caregiver and child (when the service recipient is a minor) to reduce or deescalate the identified behavior. MOCR teams may work with immediately family, kinship relation, or non-kinship primary caregiver and child for the follow-up interaction to the initial face-to-face contact.	MOCR Follow-Up services can be provided to individuals/families who have experienced a mental health or substance use-related crisis within the last 48 hours. As with the initial MOCR response, the MOCR team may work with immediate family, kinship or non-kinship primary caregiver and child (when the service recipient is a minor) as is appropriate for the individual's needs.
Staff Qualifications	MOCR Crisis Services Follow Up may be staffed by a multidisciplinary team of qualified professionals. Providers qualified to be reimbursed for eligible services include: • Licensed Physicians • Licensed Physician Assistants • Advanced Practice Registered Nurses • Licensed Registered Nurses • Licensed Practical Nurses • Mental Health Professional Clinicians • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistants • Community Health Aides	No suggested changes

Service Name (Abbreviation)	MOCR Crisis Service Follow Up	Proposed Updated Language
	• Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialists	
Service Location	Services may be provided in the following settings: 03 - School 04 - Homeless Shelter 05 - Indian Health Service Free-standing Facility 06 - Indian Health Service Provider-based Facility 07 - Tribal 638 Free-standing Facility 08 - Tribal 638 Provider-based Facility 11 - Office 12 - Home 13 - Assisted Living Facility 14 - Group Home 15 - Mobile Unit 16 - Temporary Lodging 18 - Place of Employment 19 - Off Campus-Outpatient Hospital 22 - On Campus-Outpatient Hospital 23 - Emergency Room 26 - Military Treatment Center 49 - Independent Clinic 50 - Federally Qualified Health Center 52 - Partial Hospitalization Program 53 - Community Mental Health Center	No suggested changes

Service Name (Abbreviation)	MOCR Crisis Service Follow Up	Proposed Updated Language
	54 - Intermediate Care Facility/ Individuals with Intellectual Disabilities 55 - Residential Substance Abuse Treatment Facility 56 - Psychiatric Residential Treatment Center 57 - Non-residential Substance Abuse Treatment Center 58 - Non-residential Opioid Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility 71 - State or local Public Health Clinic 72 - Rural Health Clinic 99 - Other appropriate place of service Telehealth may be allowable for this service if prior authorization is obtained.	
Service Frequency/ Limits	None	No suggested changes
Service Authorization	No service authorization required	No suggested changes
Service Documentation	Must be documented in a progress note in accordance with 7 AAC 139.350.	No suggested changes
Relationship to Other Services	MOCR crisis services follow up may be provided concurrently with any service listed in standards manual that is not otherwise contraindicated.	No suggested changes
Service Code	H2011 TS V1 H2011 TS V2	H2011 TS
Unit Value	1 unit = 15 minutes	No suggested changes

Service Name (Abbreviation)	MOCR Crisis Service Follow Up	Proposed Updated Language
Payment Rate	See rate chart	Pending rate review
Additional Information	Programs may employ a multidisciplinary team of professionals to perform MOCR; however, each unit of service must be provided by a mental health professional clinician or other qualified professional listed in staff qualifications to be eligible to draw down the per unit rate. Qualified providers of MOCR services are recommended to follow the SAMHSA “Essential Principles for Modern Crisis Care Systems” from the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit Executive Summary. (Attachment A) https://www.samhsa.gov/sites/default/files/national-guidelines-forbehavioral-health-crisis-services-executive-summary-02242020.pdf	<i>Language can be removed</i>

Appendix C: High Level Comparison of Place-Based Models < 24 Hours

FIGURE 6: COMPARISON OF PLACE-BASED MODELS UNDER 24 HOURS

Components	High Acuity	Moderate Acuity		Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Center	BH Urgent Care	Living Rooms and Sobering Centers
BH Acuity	High Acuity - Danger to self/others, acute agitation, significant intoxication/withdrawal	Moderate acuity - broad range of psychiatric and medical acuity is possible and highly dependent on staffing requirements.	Moderate Acuity - Range of psychiatric and medical acuity is possible dependent on BH Urgent Care staffing.	Low acuity - Needs engagement and help with social stressors and/or lower acuity behavioral health symptoms that do not require intervention by a clinician.
Medical Acuity	Ambulatory-level care support for any physical health issue	Ambulatory-level care support for any physical health issue - may be restricted due to staffing structure	Ambulatory-level care support for any physical health issue - may be restricted due to staffing structure	N/A - unable to provide ambulatory-level care support
Voluntary/Involuntary	Voluntary and/or Involuntary (No Barrier)	Voluntary Only (Low Barrier)	Voluntary Only (Low Barrier)	Voluntary Only (Low Barrier)
Seclusion and Restraint Capable	Yes (if involuntary admissions accepted)	No	No	No
Population Served	Intensive treatment to individuals who meet hospital inpatient criteria and are highly monitored to keep individuals receiving care and staff safe. Most individuals can be stabilized and discharged within 24 hours.	The population characteristics that moderate-intensity units can manage range in the design and requirements of these facilities. Generally, these facilities admit individuals who are not a risk to themselves or others, are voluntary admits, have withdrawal symptoms that can be managed at the appropriate ASAM level that is staffed, and can be stabilized and discharged within 24 hours.	BH Urgent Care offers a safe, low-barrier, voluntary, and timely alternative and diversion from the use of hospital Eds or more intensive crisis services as an entry point to care to address the needs of individuals experiencing behavioral health crises. Provides walk-in voluntary outpatient services with extended operating hours.	These low acuity crisis programs provide engagement and support to assist individuals in crisis, offering support, respite, and referral to clinical and non-clinical services and resources in the community.
Exclusionary Criteria	Medical conditions that require interventions beyond that of an ambulatory level medical setting,	Involuntary admissions; conditions that require interventions beyond that of an ambulatory level medical setting; acute behavioral health conditions that require more intensive service environment and	Involuntary admissions; Individuals with medical needs beyond the capacity of the BHUC or those who are at imminent risk of harm to self, others, or property who cannot engage or do not wish to engage in safety planning may be referred to a more appropriate level of care.	Involuntary admissions

Components	High Acuity	Moderate Acuity		Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Center	BH Urgent Care	Living Rooms and Sobering Centers
		individuals who need medically monitored care.		
Detox/Withdrawal Capabilities (Note: Withdrawal Management Levels are based on ASAM 3 rd Edition. ASAM 4 th Edition includes a 3.1 WM level, and should be considered, as appropriate, for moderate and low acuity settings based on population needs)	ASAM 3.7 (medically supervised detox); high medical/nursing involvement, hospital level safety standards. These centers can provide withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting.	ASAM 3.7 or 3.2; Variable levels of med/nursing. There is flexibility in the acuity of withdrawal that can be managed. Generally can handle moderate symptoms of intoxication and withdrawal.	N/A - ambulatory only	ASAM 3.2 (sobering/"social detox")
MOUD/MAUD Initiation	Yes	Yes	Yes	No
Length of Stay	<24 hours	<24 hours	<24 hours; not a longitudinal service	<24 hours
Operating Hours	24/7/365	24/7/365 (could provide less)	Extended hours up to 24/7/365	Up to 24/7/365
Psychiatric Coverage	Onsite coverage 24/7 Licensed behavioral health staff (social workers, counselors, marriage and family therapists) 24/7/365 Must meet all licensing requirements in accordance with Alaska's Subacute Facility Licensure requirements.	Mix of onsite and on call coverage, including telehealth Licensed behavioral health staff are not required to be onsite at all times	Coverage by a psychiatrist or other credentialed provider with prescribing capabilities either onsite or via telehealth during BHUC operation hours. Licensed behavioral health staff (social workers, counselors, marriage and family therapists) onsite during BHUC operating hours.	Variable, but not a required element of all models as some low acuity models utilize peer-based supports and may refer to clinical care.
Medical Staffing and Capability	Have on-site medical professionals (psychiatrist, advanced practice nurses, registered nurses) available 24/7.	Nursing involvement can range from 24/7 onsite nursing care to various combinations of onsite	Qualified nursing staff (RN/LPN) onsite during BHUC operating hours	With a lower acuity population, medical and nursing staff are not required onsite 24/7/365;

Components	High Acuity	Moderate Acuity		Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Center	BH Urgent Care	Living Rooms and Sobering Centers
	Capable of conducting medical assessments, administering medications, performing basic labs, and managing co-occurring physical health conditions. Coverage by a psychiatrist or other credentialed non-physician psychiatric provider with prescribing capabilities (accessible immediately onsite or virtually 24/7/365) Nursing staff onsite 24/7/365. A Registered Nurse shall be onsite at all times in accordance with Alaska's Subacute Facility Licensure requirements.	and on-call coverage. Staffed primarily by behavioral health clinicians and peer support specialists. Medical professionals are not always on-site and may only be available via telehealth or on-call. Limited to medication support and basic medical triage. Nursing staff - recommended to be onsite 24/7, but may provide nursing services on-call, if needed		instead, they will meet individuals receiving care once a day or as needed.
Onsite Facility Capabilities	Onsite pharmacy or medication dispensing capabilities that align to Alaska's Subacute Facility Licensure requirements. Shall have laboratory services to meet the needs of its patients either onsite with CLIA waiver or through contracted services that meet Alaska's Subacute Facility Licensure requirements. Secure facility with delayed egress on all exterior doors in accordance with Alaska's Subacute Facility Licensure requirements. Seclusion/restraint onsite (if the facility accepts involuntary admissions)	Must have access to local pharmacy services that can enable access to medications for people who need this service while at the center. No seclusion/restraint onsite	Can be a stand-alone center; however, may be an adjunct service to a hospital, a more intensive service, or a longitudinal ambulatory clinic.	No pharmacy requirements. Home like setting, not secure No seclusion/restraint onsite

Components	High Acuity	Moderate Acuity		Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Center	BH Urgent Care	Living Rooms and Sobering Centers
Receiving Center	Must be available to serve as a receiving center for law enforcement and first-responder drop-offs and have the capability to accept both voluntary and involuntary individuals if designated as accepting involuntary admissions. ("No Wrong Door")	Serves as a receiving center for voluntary admissions. Works with law enforcement and first-responders to divert appropriate individuals to care. These facilities may not provide designated drop-off for law enforcement but should facilitate ease of drop-off to incentivize use of the facility to divert from EDs and jails.	No requirement to be a receiving center for police and/or EMS but building strong relationships with first responders is encouraged to ensure access to care and diversion from ED and jail when appropriate.	No requirement to be a receiving center for police and/or EMS but building strong relationships with first responders is encouraged to ensure access to care and diversion from ED and jail when appropriate.
Security and Observation	May have secure, contained, or "locked" areas, with higher levels of observation and staff intervention to manage agitation, violence risk, or medical instability.	Operate in an unlocked, open environment, with standard observation practices and less frequent need for intensive staff intervention.	Ambulatory outpatient setting.	Operates in a "home" like environment where individuals are free to come and go.
Scope and Depth of Clinical Services	In accordance with Alaska's Subacute Facility Licensure requirements, the facility must provide the following treatment services: • Emergency screening, • Individual crisis assessment, • Psychiatric evaluation services, • Nursing services, • Crisis intervention and stabilization services that include therapeutic interventions to decrease and stabilize the presenting crisis, • Identification and resolution of the factors contributing to the crisis when possible • Stabilization of withdrawal symptoms if appropriate • 24-hour observation • Advocacy, networking, and support to provide linkages and referrals to appropriate community-based services	Focus on behavioral health assessment, crisis intervention, brief stabilization, and basic medication support.	Assess and stabilize mental health and SUD-related crisis. Provide a clinical assessment that includes an evidence-based safety assessment for dangerousness to self or others and create a crisis plan that includes a safety plan to mitigate the acute crisis and safety risk.	May utilize clinical staff to provide crisis counseling and other therapeutic interventions. The service, however, is often centered around peer support and/or sobering without treatment.

Components	High Acuity	Moderate Acuity		Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Center	BH Urgent Care	Living Rooms and Sobering Centers
	- Medication services, including prescription, administration, and management - Follow-up care			
Physical Environment	Clinical, medical-oriented setting with specialized safety features for managing high-risk situations. Capable of seclusion and restraint if involuntary admissions are accepted.	Community-based, non-clinical environment designed to be welcoming and less restrictive. Does not have seclusion and restraint.	Outpatient clinic setting.	Operates in a "home" like environment where individuals are free to come and go.
Licensure and Accreditation	Require higher levels of licensure and regulatory oversight, often similar to inpatient or medical facilities. Alaska's Subacute Facility Licensure requirements apply.	Subject to behavioral health facility licensure, with fewer medical regularity requirements. Sub-acute facility regulations would not apply.	Should be accredited/licensed by appropriate authority.	Site may be accredited through a body such as the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or CARF.

Appendix D: High Level Comparison of Place-Based Models > 24 Hours

FIGURE 7: COMPARISON OF PLACE-BASED MODELS OVER 24-HOURS

Components	High Acuity	Moderate Acuity	Moderate Low Acuity	Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Extended Residential Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Extended Residential Center	Referral Based Crisis Residential	Residential Crisis Respite
BH Acuity	High Acuity - Danger to self/others, acute agitation, significant intoxication/withdrawal	Moderate acuity - broad range of psychiatric and medical acuity is possible and highly dependent on staffing requirements.	Low to Moderate Acuity - Range of psychiatric and medical acuity is possible dependent on staffing.	Low acuity - Needs engagement and help with social stressors and/or lower acuity behavioral health symptoms that do not require intervention by a clinician.
Medical Acuity	Ambulatory-level care support for any physical health issue	Ambulatory-level care support for any physical health issue - may be restricted due to staffing structure	Ambulatory level care support for physical health issues - may be restricted due to staffing structure	N/A
Voluntary/Involuntary	Voluntary and/or Involuntary (No Barrier)	Voluntary Only (Low Barrier)	Voluntary Only (Low Barrier)	Voluntary Only (Low Barrier)
Seclusion and Restraint	Yes (if involuntary accepted)	No	No	No
Population Served	Individuals who are presenting with acute symptoms of intoxication due to substance use, or mental or emotional distress or who need a secure environment for evaluation and stabilization. Voluntary and involuntary admissions are accepted.	Individuals who are presenting with acute symptoms of mental or emotional distress or who need a secure environment for evaluation and stabilization. Voluntary admissions are accepted.	These low acuity crisis programs provide engagement and support to assist individuals in crisis, offering support, respite, and referral to clinical and non-clinical services and resources in the community. Serve voluntary only who are not at risk to themselves or others and have withdrawal symptoms that can be managed at the appropriate ASAM level that is staffed	These low acuity crisis programs provide engagement and support to assist individuals in crisis, offering support, respite, and referral to clinical and non-clinical services and resources in the community.
Exclusionary Criteria	Medical conditions that require interventions beyond that of an ambulatory level medical setting,	Involuntary admissions; conditions that require interventions beyond that of an ambulatory level medical setting; acute behavioral health conditions that require more intensive service environment	Individuals with medical needs beyond the capacity of the facility or those who are at imminent risk of harm to self, other, or property who cannot engage or do not wish to engage in safety planning may be referred to a more appropriate level of care. Involuntary Admissions (excluded)	Involuntary admissions are excluded People who cannot safely be supported in this service environment may be connected to a different level of care. People may request referrals to other resources.

Components	High Acuity	Moderate Acuity	Moderate Low Acuity	Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Extended Residential Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Extended Residential Center	Referral Based Crisis Residential	Residential Crisis Respite
Detox/Withdrawal Capabilities (Note: Withdrawal Management Levels are based on ASAM 3 rd Edition. ASAM 4 th Edition includes a 3.1 WM level, and should be considered, as appropriate for moderate and low acuity settings based on population needs)	ASAM 3.7 (medically supervised detox); high medical/nursing involvement, hospital level safety standards. These centers can provide withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting.	ASAM 3.7 WM or 3.2 WM. Variable levels of med/nursing. There is flexibility in the acuity of withdrawal that can be managed. Can generally handle moderate symptoms of intoxication and withdrawal. (Note: Withdrawal Management Levels are based on ASAM 3 rd Edition. ASAM 4 th Edition includes a 3.1 WM level, and should be considered, as appropriate, for moderate and low acuity settings based on population needs)	Can provide withdrawal management for mild and moderate symptoms level. (Equivalent to 3.2 Level WM ASAM) (Note: Withdrawal Management Levels are based on ASAM 3 rd Edition. ASAM 4 th Edition includes a 3.1 WM level, and should be considered, as appropriate, for moderate and low acuity settings based on population needs)	N/A
MOUD/MAUD Initiation	Yes	Yes	Yes	No
Length of Stay	>24 hours, up to 7 days	>24 hours, up to 7 days	>24 hours; up to 14 days	>24 hours, up to 7 days
Operating Hours	24/7/365	24/7/365	24/7/365	Up to 24/7/365
Psychiatric Coverage	Onsite coverage 24/7 Licensed behavioral health staff (social workers, counselors, marriage and family therapists) 24/7/365 Have onsite medical professionals (psychiatrist, advanced practice nurse, registered nurses) available 24/7. Capable of conducting medical assessments, administering medications, performing basic labs, and managing co-occurring physical health conditions. Coverage by a psychiatrist or other credentialed non-physician psychiatric provider with prescribing capabilities (accessible immediately onsite or virtually 24/7/365. Must meet all licensing requirements	Mix of onsite and on call coverage Licensed behavioral health staff are not required to be onsite at all times	Coverage by a psychiatrist or other credentialed provider with prescribing capabilities (although not 24/7/365) and typically provide onsite service once weekly. Skilled nursing staff (RN availability variable) LPN/EMT onsite 24/7/365 Licensed behavioral health staff (social workers, counselors, marriage and family therapists) onsite during BHUC operating hours Social support staff	No psychiatrist or physician with prescriber capabilities onsite. Licensed Mental Health Professional available on call to provide crisis intervention, assessment, and safety planning.

Components	High Acuity	Moderate Acuity	Moderate Low Acuity	Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Extended Residential Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Extended Residential Center	Referral Based Crisis Residential	Residential Crisis Respite
	in accordance with Alaska's Subacute Facility Licensure requirements.			
Medical Staffing and Capability	Have on-site medical professionals (psychiatrist, advanced practice nurses, registered nurses) available 24/7. Capable of conducting medical assessments, administering medications, performing basic labs, and managing co-occurring physical health conditions. Coverage by a psychiatrist or other credentialed non-physician psychiatric provider with prescribing capabilities (accessible immediately onsite or virtually 24/7/365) Registered Nurse onsite 24/7/365 Must meet all licensing requirements in accordance with Alaska's Subacute Facility Licensure requirements.	Staffed primarily by behavioral health clinicians and peer support specialists. Medical professionals are not always on-site and may only be available via telehealth or on-call. Limited to medication support and basic medical triage. Nursing staff - recommended to be onsite 24/7	Qualified nursing staff (RN)'s time may be variable to needs of the facility. Physician/prescriber on call 24/7 when not onsite (scheduled to be onsite no less than 1 x week)	N/A
Onsite Facility Capabilities	Onsite pharmacy or medication dispensing capabilities align to Alaska's Subacute Facility Licensure requirements. Shall have laboratory services to meet the needs of its patients either onsite with CLIA waiver or through contracted services that meet Alaska's Subacute Facility Licensure	May not have onsite pharmacy or medication dispensing equipment but do have access to local pharmacy services that can enable access to medications for people who need this service while at the center. Should be secure No seclusion/restraint onsite	Settings are consistent with accreditation body standards for physical settings of behavioral health residential units. Individual beds with private space available, no more than 16 beds. Staff secured setting Meal service tailored to dietary needs.	No pharmacy requirements. Home like setting, not secure No seclusion/restraint onsite Accepts voluntary only Communal gathering area

Components	High Acuity	Moderate Acuity	Moderate Low Acuity	Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Extended Residential Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Extended Residential Center	Referral Based Crisis Residential	Residential Crisis Respite
	requirements. Secure facility with delayed egress on all exterior doors in accordance with Alaska's Subacute Facility Licensure requirements. Seclusion/restraint onsite (if the facility accepts involuntary admissions)		No seclusion or restraint	
Receiving Center	Must be available to serve as a receiving center for law enforcement and first-responder drop-offs and have the capability to accept both voluntary and involuntary individuals if designated as accepting involuntary admissions. ("No Wrong Door.")	Is not required to provide a first-responder drop-off, but should work closely with first-responders. Is capable of admitting voluntary admissions	All admissions made by referral - not a receiving center.	No requirement to be a receiving center for police and/or EMS but building strong relationships with first responders is encouraged to ensure access to care and diversion from ED and jail when appropriate.
Security and Observation	May have secure, contained, or "locked" areas, with higher levels of observation and staff intervention to manage agitation, violence risk or medical instability.	Operate in an unlocked, open environment, with standard observation practices and less frequent need for intensive staff intervention.	Typically in a secure setting	Operates in a "home" like environment where individuals are free to come and go.
Scope and Depth of Clinical Services	In accordance with Alaska's Subacute Facility Licensure requirements, the facility must provide the following treatment services: • Emergency screening, • Individual crisis assessment, • Psychiatric evaluation services, • Nursing services, • Crisis intervention and stabilization services that include therapeutic interventions to decrease and stabilize the presenting crisis,	Focus on behavioral health assessment, crisis intervention, brief stabilization, and basic medication support. Does not provide intensive medical care or manage withdrawal from substances.	Access to psychiatric services and nursing services. Program is non-hospital based with lengths of stay that typically range from a few days to two weeks and allows for intensive 24/7 monitoring and support as well as provision of medical, nursing and crisis intervention.	The service is often centered around peer support and/or sobering without treatment. Peer crisis respite services individuals who are in need, due to experiencing a mental health crisis and/or distress, to supportive peer led services in a non-clinical setting.

Components	High Acuity	Moderate Acuity	Moderate Low Acuity	Low Acuity
Models (examples)	High-Intensity Sub-Acute Crisis Extended Residential Center (must align to Alaska's Subacute Facility Licensure regulations)	Moderate-Intensity Crisis Extended Residential Center	Referral Based Crisis Residential	Residential Crisis Respite
	• Identification and resolution of the factors contributing to the crisis when possible • Stabilization of withdrawal symptoms if appropriate • 24-hour observation • Advocacy, networking, and support to provide linkages and referrals to appropriate community-based services • Medication services, including prescription, administration, and management • Follow-up care			
Physical Environment	Clinical, medical-oriented setting with specialized safety features for managing high-risk situations. Capable of seclusion and restraint if involuntary admissions are accepted.	Community-based, non-clinical environment designed to be welcoming and less restrictive. Does not have seclusion and restraint (outpatient setting).	Community-based residential setting	Operates in a "home" like environment where individuals are free to come and go.
Licensure and Accreditation	Require higher levels of licensure and regulatory oversight, often similar to inpatient or medical facilities. Alaska's Subacute Facility Licensing regulations apply.	Subject to behavioral health facility licensure, with fewer medical regularity requirements. Subacute Facility Licensure not required..	Subject to behavioral health facility licensure for residential settings. Subacute Facility Licensure not required.	Site may be accredited through a body such as the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or CARF.

Appendix E: Continuum of < 24 Hour Place-Based Crisis Stabilization Services

FIGURE 8. CONTINUUM OF < 24 HOUR PLACE-BASED CRISIS STABILIZATION SERVICES: SERVICE CATEGORIES, ACUITY, AND KEY FEATURES

Service	Acuity (Physical Health)	Withdrawal Level	MAUD/MOUD Access	Key Features
High-Intensity Sub-Acute Crisis Stabilization Center	High – Able to accommodate all ambulatory-level care for any physical health issues.	ASAM 3.7-WM – Medically Monitored	Y	• “No-barrier” or “no wrong door” access • May use seclusion and restraint • Highest level of onsite medical and psychiatric staffing • Secure/locked facility • Rapid drop off from police/EMS
Moderate-Intensity Crisis Stabilization Center	Moderate – Ambulatory-level care support for physical health issues – more limited and dependent on staffing than high-intensity.	ASAM 3.2-WM– Clinically monitored with medication (Note: Withdrawal Management Levels are based on ASAM 3 rd Edition. ASAM 4 th Edition includes a 3.1 WM level, and should be considered, as appropriate, for moderate and low acuity settings based on population needs)	Y	• “Low-barrier” access • Reduced medical and psychiatric staffing onsite • Serves as a receiving center or drop-off from police/EMS • Not locked/secured
BH Urgent Care	Moderate – Ambulatory-level care support for any physical health issues	ASAM 1-WM - Ambulatory	Y	• “Low-barrier” access • Time-limited, targeted service • Outpatient services with extended operating hours • Provide walk-in voluntary services • Care coordination and linkage to longitudinal care
Sobering Center	Low – No medical care requirements for physical health conditions	Observation, support, and referral	N	• “Low-barrier” access • Oversight of adults with acute intoxication • Not a treatment service • Provide walk-in voluntary services • Provide community resource linkages and referrals • Provide in-person, telephonic, or virtual follow-up (integrate peers for follow-up)
Living Room (non-residential, peer-support driven)	Low – no medical care requirements for physical health conditions	None	N	• “Low-barrier” access • Peer-operated/centered service • Non-residential • Flexible operating hours to meet community needs

FIGURE 9. CONTINUUM OF < 24 HOUR PLACE-BASED CRISIS STABILIZATION SERVICES: STAFFING REQUIREMENTS AND GUIDANCE

Service	Medical Staffing	Psych Staffing	Direct Care Staffing	Notes
High-Intensity Sub-Acute Crisis Stabilization Center	- Nursing staff on-site 24/7: 1:8 ratio or lower - Coverage by psychiatrist or other credentialed provider with prescribing capabilities (NPs or PAs (PA requires physician supervision)) 24/7; may be available in person or via telehealth.	- On-site coverage 24/7 by a licensed MH clinician: 1:16 ratio or lower - Coverage by psychiatrist or other credentialed provider with prescribing capabilities 24/7; may be available in person or via telehealth.	- Staffing ratio: 1:4 (peak hours); 1:6 (non-peak hours) - Substance Use Disorder Counselor - CMA or CNA - Community Health Aides - BH Clinical Associates - BH Health Aides - Peer Support Specialists	- May share staffing with an extended crisis stabilization center, if co-located, when necessary, provided that adequate staffing remains in both units. Staff sharing must comply with Alaska's Subacute Facility Licensure regulations. - Recliners - Capable of admitting involuntary admits and has capabilities to use seclusion and restraint if appropriate
Moderate-Intensity Crisis Stabilization Center	- Nursing staff is recommended on-site 24/7 at a ratio of 1:16 - Coverage by prescriber onsite or via telehealth 24/7 (NPs or PAs with physician supervision)	Licensed mental health clinician, while not required to be on-site 24/7, should be accessible for assessment within 1 hour and be onsite during peak business hours	- Staffing ratio: 1:8 - Substance disorder counselor - CMA or CNA - Community Health Aides - BH Clinical Associates - BH Health Aides - Peer Support Specialists	- May share staffing with an extended crisis stabilization center, if co-located, when necessary, provided that adequate staffing remains (i.e., an LPN) in both units. - Opportunity to require either nursing staff or licensed MHP to be on-site at all times with on-call availability
BH Urgent Care	Coverage by a psychiatrist or other credentialed provider with prescribing capabilities either on-site or via telehealth during BHUC operating hours	Licensed BH staff onsite during BHUC operating hours	- Other staff found in an outpatient BH clinic setting - Peer Support - MHP - Care Coordinator	- Outpatient/clinic setting - Can be stand-alone center or may be an adjunct service to a hospital, a more intensive crisis service, or a longitudinal ambulatory clinic
Sobering Center	Minimum of two staff, with minimum certification equivalent to an emergency medical technician, are onsite at all times during operations	Licensed behavioral health staff – variable. Should consider coordination for assessment or brief crisis intervention	- Minimum of two staff should be onsite during operating hours. - Peer support specialist - Certified CDC - MHP	- Not a treatment service - Harm reduction and recovery framework - Staff should receive significant training including de-escalation techniques
Living Room (non-residential, peer-support driven)	RN may be utilized to support the Living Room model but is not required.	One licensed clinician on-site during operating hours or available for consultation during site operating hours. At least one peer support specialist on-site during operating hours	- Admin staff = manage intake and maintain welcoming environment - Program supervisor - Case managers (optional)	- People who cannot be safely supported in this service environment may be connected to a different level of care. - People may request referrals to other resources - LOS is variable. Recommend maximum stay of 7 days - Dedicated beds for individuals staying overnight

Appendix F: Continuum of > 24 Hour Place-Based Crisis Stabilization Service

FIGURE 10. CONTINUUM OF > 24 HOUR PLACE-BASED CRISIS STABILIZATION SERVICES: SERVICE CATEGORIES, ACUITY, AND KEY FEATURES

Service	Acuity (Physical Health)	Withdrawal Level	MAUD/MOUD Access	Key Features
High-Intensity Sub-Acute Extended Crisis Residential	High – Able to accommodate all ambulatory-level care for any physical health issues.	ASAM 3.7 WM – Medically Monitored	Y	• Admissions from co-located high-intensity sub-acute stabilization center • May use seclusion and restraint • Highest level of onsite medical and psychiatric staffing • Secure/locked facility • Bed and separate rooms are provided • Must meet Alaska's Subacute Facility Licensure regulations.
Moderate-Intensity Extended Crisis Residential	Moderate – Ambulatory-level care support for physical health issues – more limited and dependent on staffing than high-intensity.	ASAM 3.2 WM – Clinically monitored with medication (Note: Withdrawal Management Levels are based on ASAM 3 rd Edition. ASAM 4 th Edition includes a 3.1 WM level, and should be considered, as appropriate, for moderate and low acuity settings based on population needs)	Y	• Admissions from co-located moderate-intensity sub-acute stabilization center and other sources • Reduced medical and psychiatric staffing onsite as compared to high-intensity crisis residential • Not a secure/locked facility • Bed and separate rooms are provided
Peer Crisis Residential Respite	Low – No medical care requirements for physical health conditions	N/A	N	• Peer directed service • Home like environment • Consumers are free to come and go • Provide support and referrals to resources • Provide follow-up crisis support
Crisis Residential (referral-based)	Moderate/Low - Limited ability to treat physical health needs dependent on staffing	ASAM 3.2 WM – Clinically monitored (Note: Withdrawal Management Levels are based on ASAM 3 rd Edition. ASAM 4 th Edition includes a 3.1 WM level, and should be considered, as appropriate, for moderate and low acuity settings based on population needs)	Y	• Not co-located with a crisis stabilization and receiving center. • Referrals required – does not act as a receiving center but may coordinate entry with police/EMS or community service providers • Not a treatment service • The state could provide options for different levels of support aligned to staffing requirements

FIGURE 11. CONTINUUM OF > 24 HOUR PLACE-BASED CRISIS STABILIZATION SERVICES: SERVICE CATEGORIES, ACUITY, AND KEY FEATURES

Service	Medical Staffing	Psych Staffing	Direct Care Staffing	Notes
High-Intensity Sub-Acute Extended Crisis Residential	- Nursing staff on-site 24/7: 1:8 ratio or lower - Coverage by psychiatrist or other credentialed provider with prescribing capabilities (NPs. Or PAs with physician supervision) 24/7. May be available in person or via telehealth.	- On-site coverage 24/7 by a licensed MH clinician: 1:16 ratio or lower - Coverage by psychiatrist or other credentialed provider with prescribing capabilities 24/7 May be available in person or via telehealth.	- Staffing ratio: 1:4 (peak hours); 1:6 (non-peak hours) - Substance Use Disorder Counselor - CMA or CAN - Community Health Aides - BH Clinical Associates - BH Health Aides - Peer Support Specialists	- May share staffing with a co-located high-intensity crisis stabilization center, when necessary, provided that adequate staffing remains in both units and in accordance with Alaska's Subacute Facility Licensure requirements. - Recommend not more than 7-10 day LOS - Has capabilities to use seclusion and restraint if appropriate
Moderate-Intensity Extended Crisis Residential	Nursing staff is recommended on-site 24/7 at a ratio of 1:16, but not required during all hours of operations but must have on-call nursing support when not on-site Coverage by prescriber onsite or via telehealth 24/7 (NPs or PAs with physician supervision)	Mix of onsite and on call coverage. Licensed BH staff are not required to always be on-site, but should be in person during peak hours and available on-call or via telehealth 24/7	- Staffing ratio: 1:8 - Substance disorder counselor - CMA or CAN - Community Health Aides - BH Clinical Associates - BH Health Aides - Peer Support Specialists	- May share staffing with a co-located moderate-intensity crisis stabilization center, when necessary, provided that adequate staffing remains in both units. - Recommend not more than 7-10 day LOS - No seclusion or restraints
Peer Crisis Residential Respite	N/A. Staff should assist individuals with referral to medical and behavioral health treatment services, if appropriate.	Licensed Mental Health Professional on-call to provide assessment, crisis intervention, and safety planning.	At least one peer support specialist is always on-site when there is a guest	- People who cannot safely be supported in this service environment may be connected to a different level of care. - LOS is variable. Recommend max stay of 7 days - Dedicated bed for individuals staying overnight
Crisis Residential (referral-based)	- Coverage by a psychiatrist or other credentialed provider with prescribing capabilities (no 24/7/365 requirement) – usually on-site 1 x week - RN availability variable - LPN/EMT onsite 24/7/365	Licensed behavioral health staff – variable. Should consider coordination for assessment or brief crisis intervention	- Substance disorder counselor - CMA or CAN - Community Health Aides - BH Clinical Associates - BH Health Aides - Peer Support Specialists	- Explore ability to share staffing across programs - LOS requirements are flexible. Recommend LOS in the range of 7-14 days to provide a place-based option that extends crisis support to the medical necessity of individuals in need - Typically, stand-alone facilities not connected to a crisis receiving center

Limitations

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and State of Alaska Department of Health (DOH).

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Alaska's current behavioral health crisis system includes services authorized under the Medicaid State Plan and others through the 1115 Waiver. The focus of this work was on service standards associated with the 1115 Waiver, such as Mobile Outreach and Crisis Response (MOCR), MOCR Crisis Service Follow-Up, 23-Hour Crisis Stabilization and Observation, Crisis Residential Stabilization, and Peer-Based Crisis Services.