

# Integrated Care & State Policy in Alaska: *Case Study of Anchorage Neighborhood Health Center*



**August 2016**

## **Introduction**

Health centers have a habit of starting with nothing; nothing but the power of a vision of what *should* be. They are not built brick by brick, but rather they are formed in the mind of someone with a stubborn unwillingness to accept the status quo. These people are uncommon; they are idealists, change-makers, seed-planters, need-fillers, risk-takers and problem-solvers. These were the people of Anchorage in the early 1970s whose vision formed Anchorage Neighborhood Health Center.

## **Life in Alaska**

It was easy to be sick and poor in Alaska at that time. The fur and gold trades had boomed for a while, but then went bust when the furs were depleted and gold became difficult to scratch from the Alaskan soil. The military had planted bases in Anchorage and throughout Alaska to keep a closer eye on Japan and Russia. The oil bonanza of the late 1970s and 1980s had not yet begun, and cruise ships filled with moneyed tourists had not yet sailed.

## **Anchorage Neighborhood Health Center**

It was into this awkward adolescent economy that the Anchorage Neighborhood Health Center (ANHC) was born. The year 1974 saw the start of a monstrously large Trans-Alaska Pipeline and the infancy of a tiny health center. Both would impact the lives of generations of Alaskans to come.

ANHC began with a handful of clinicians in a trailer. Its mission then, and today, is “to improve wellness by providing high-quality, compassionate healthcare regardless of ability to pay.” As the largest federally-qualified health center (FQHC) in Alaska, ANHC provides medical, dental, lab, radiology and pharmacy services to over 12,000 active patients through more than 40,000 annual visits.

ANHC enjoys a new facility with 45 exam, procedure, and medical consultation rooms designed in three medical suites in the health center, and 5 full-time primary care providers (PCPs) in each. It has 10 dental operatories, as well as specialty behavioral health and integrated behavioral health services. Patient education space is available for consultations on diabetes and other chronic conditions. It is a patient-centered medical home (PCMH) Level III.

ANHC has a 16-member Board of Directors and approximately 140 staff members.

## **Journey to Integrated Care**

As in health centers all across the country, many of ANHC’s patients find themselves at the unwelcome nexus of poverty and chronic illness. Cancer, depression, domestic violence and youth/adolescent obesity plague the

community. Alaskans 25 years and older are committing suicide at high rates, children aren't being properly immunized and rampant dental disease remains an ongoing challenge<sup>1</sup>.

On the positive side, kids are using less tobacco; progress is being made with adult obesity; suicides among young people 15 to 24 years of age is down; there's a noticeable decrease in binge drinking; and the unintentional injury mortality rate is less. (Healthy Alaskans 2020: Leading Health Priorities)

In reviewing patient surveys over the last five years, ANHC recognized a consistent request for more behavioral health resources within the clinic. ANHC worked to meet the complex behavioral health and medical needs of a growing patient population, particularly as access to community-based behavioral health resources continued to decline. In addition, while the Uniform Data System (UDS) measures for clinical quality indicators for 2011-2015 were at or near national levels, the trend line suggested leveling off rather than showing continued improvements. ANHC leaders decided that behavioral health interventions, in addition to the ongoing patient education and routine provider care, may turn the trend to meet and exceed national measures for diabetes, hypertension and depression management.

Over the past 10 years, ANHC has gone through multiple iterations of behavioral health care collaboration in an effort to find the best fit. Initially, ANHC collaborated with off-site psychologists and psychiatrists, but the identified need and demand for ongoing therapy *quickly* exceeded supply of the collaborating specialists. The organization then embedded a psychiatric nurse practitioner for medication management, but experienced difficulty reassigning medication management back to the PCP, thus further siloing behavioral health care.

ANHC then hired a part-time co-located psychologist on-site, and again, demand for long-term therapy quickly exceeded supply of the part-time clinician. In 2014-2015, doctoral level psychology interns began providing one-on-one psychotherapy. These co-located psychologists were assigned one per medical suite (three suites total) in the health center. In an attempt to keep up with the volume of patients referred for new behavioral health evaluations, sessions were limited to 45 minutes or less. However, given the complexity of conditions, the treatment model drifted back to traditional, long-term therapy, virtually eliminating capacity for new referrals from the PCPs after the first 6 months. Within this model, Patients were able to self-refer to these therapists, and there were no set goals or timelines for the duration of therapy. While the psychologists were co-located in the medical suites, they had minimal direct primary care team interactions. In short, ANHC had unintentionally created three private practices co-located within their health center.

In April 2015, ANHC's leadership team began reworking their behavioral health program. It hired a part-time psychologist, 2 full-time licensed clinical social workers (LCSWs) and a full-time psychiatric nurse practitioner. This group of individuals became their "integrated behavioral health team." The behavioral health providers' roles were restructured to become part of the primary care provider team. In an effort to control the volume of service requests during the first year of transition, patients were not able to self-refer: they had to be initially screened and then referred internally by their PCPs. Although these efforts to limit access were not ideal, they were necessary given the continued referral burden of the limited community behavioral health system, as well as the expanding population of ANHC (from the enrollment of over 1000 new patients in 2015).

During this time, ANHC developed a "brief intervention model" in which behavioral health team members were always "on call" for PCP consultations during clinic days. However, this model was difficult to coordinate, created interruptions in traditional therapy, and was viewed by PCPs as a behavioral health crisis resource. Within three months, demand for the three behavioral health providers exceeded their clinical capacity.

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<sup>1</sup> Healthy Alaskans 2020 report. Retrieved from <http://hss.state.ak.us/ha2020/>.

After much experimentation, creativity and innovation, the ANHC leadership team realized that at the root of their challenges, they had varying (and sometimes conflicting) views of “what behavioral health integration should look like.” After research and consultation, including on-site strategic planning, they developed a common understanding of integrated care and took the direction of using embedded behavioral health consultants in each of their three medical suites. An important change during this process was the shift from “crisis” referrals to “upstream prevention and wellness” collaborations between PCPs and behaviorists for medical and behavioral health conditions.

## Lessons Learned

Several lessons have been learned through this decade long process. These are among the most significant:

1. **Understand your demand and react appropriately.** When ANHC found that it could not meet the demands for access to behavioral healthcare with traditional models of behavioral health therapy, greater emphasis was placed on identifying those individuals who need long-term therapy and providing a referral to a community provider who can meet the need for such. The critical role of identification and development of collaborative relationships with community referrals has been a secondary lesson.
2. **Train and encourage collaboration.** Another lesson was learned through providing additional training of ANHC’s primary care and behavioral health staff, which helped them to collaboratively identify individuals who may experience a greater sense of health and well-being through brief interactions and action plans. This has helped to de-stigmatize accessing behavioral health support, as one of our patients mentioned they “do not feel like they are labeled mentally ill when they just needed someone to talk to.”
3. **Develop a sustainability plan.** A method for financially sustaining the care model will allow the staff to continue providing integrated services while the organization strategically plans for how to fulfill both the short and long-term personnel needs.

## Alaska State Policy and Integrated Care

In 2016, Alaska expanded Medicaid in an effort to cover additional low income individuals. This provided coverage for many additional ANHC patients, and reduced the volume of self-pay patients while increasing the number of Medicaid patients. This created an environment where ANHC’s financial sustainability was greatly improved.

In addition, Alaska’s state policy allows for “same day” billing. These codes, 96150 – 96155, are used by behaviorists when the patient presents with, and/or is treated for, medical conditions (diabetes, obesity, hypertension, etc.) and receives a behavioral health directed intervention for the medical condition. Traditional codes for behavioral diagnoses (depression, anxiety, obsessive-compulsive disorder, etc.) are still in use, particularly for those PCP referrals that are directly related to substance use or suspected/pre-existing mental health diagnoses. Alaska’s same day billing policy provides critical support to ANHC’s financial stability for integrated care. Operationally and financially, ANHC took steps to bill and collect for same day visits, including building scheduling and EHR templates, and training billing staff on these codes.

With Alaska’s Medicaid expansion and coverage for Health and Behavior Assessment codes, ANHC enjoys distinct advantages related to quality and financial sustainability over health centers located in states that have not gone this route.

## Conclusion

After extensive (and valiant) experimentation within its behavioral health program, ANHC is implementing a model of care that is consistent with best practices and with the definition recommended by the Agency for Healthcare Research and Quality (AHRQ):

*“The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of healthcare utilization (Peek, 2013).”*

With Alaska state policies that support the integration of primary care and behavioral health, including Medicaid expansion and payment for same-day visits and Health and Behavior Assessment codes, Anchorage Neighborhood Health Center is ideally positioned to accomplish its mission: “To improve wellness by providing high-quality, compassionate healthcare regardless of ability to pay.”

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