

Alaska Medicaid and Alaska Behavioral Health 2026 Spring Provider Outreach

May 6 & 7, 2026

9:00 am – 4:15 pm AKT

Comagine Health

UAA Alaska Center for Rural Health and Health Workforce
University of Alaska Anchorage

Welcome to Comagine Health Combined Physical & Behavioral Health Provider Education Series
Accreditation Statement & Disclosure

Approved Provider Statements: In support of improving patient care, the Alaska Department of Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education and the National Association of Boards of Pharmacy (NABP), and the American Nurses Credentialing Center (ANCC), American Academy of Physician Assistants (AAPA), American Psychological Association (APA), Association of Social Work Boards (ASWB), American Dental Association's Continuing Education Recognition Program (ADA CERP), Commission on Dietetic Registration (CDR), and the Council on Optometric Practitioner Education (COPE) to provide continuing education for the healthcare team.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

Joint Provider Statement: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint Providership of the University of Alaska Anchorage College of Health Center for Rural Health & Health Workforce (ACRH-HW). ACRH-HW is accredited by the ACCME to provide continuing education for the healthcare team.

Contact Hours: ACRH-HW designates this activity for a maximum of 8 contact hours, commensurate with participation.

- American Medical Association (AMA) Physician's Recognition Award (PRA) Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- American Nurses Credentialing Center (ANCC) Continuing Nursing Education
- Association of Social Work Boards (ASWB)
- American Psychological Association (APA)
- Other members of the Healthcare Team

CACHE
Clearinghouse of Alaska's Continuing Health Education

Financial Disclosures: No commercial or in-kind support was received for this educational activity. All speakers, reviewers, and planners report no relevant financial relationships related to the content of this activity.

Requirements for Successful Completion: To receive CE credit please make sure your attendance is recorded, you have actively engaged in the activity, and completed the course evaluation provided by the program facilitators to claim your credit.

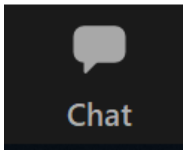
3211 Providence Drive BOC3
Suite 250, Anchorage, AK 99508
uaa_cache@alaska.edu
uaa.alaska.edu/CACHE

Agenda Day 1

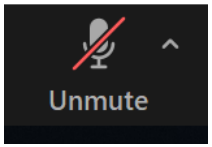
9:00-9:10 am	**Opening Remarks**
Yvette Stratton, RN, CCM Executive Director, Care Management, Comagine Health	
9:10 – 9:30 am	**State Initiatives and Updates**
Lynn Keilman Cruz Director, Division of Health Care Services	
9:30 – 9:50 am	**State Initiatives and Behavioral Health Updates**
Amaris Rosario Acting Deputy Director, Division of Behavioral Health	
9:50 – 10:50 am	**Crisis Now Initiatives and Updates**
Eric Boyer Senior Program Officer, Alaska Mental Health Trust Authority	
10:50 – 11:00 am	**Break**
11:00 am – 12:00 pm	**Integrated Behavioral Health Models**
Dr Sarah McCutcheon, MD, FAPA, BCPA Regional Medical Director. Care Management, Comagine Health	
12:00 – 1:00 pm	**Lunch Break**
1:00 – 2:00 pm	**AKTC FSTC Training Department**
Niki Knowlton, LCSW, MPH, Behavioral Health Training Coordinator for the University of Alaska, Center for Human Development, Alaska Training Cooperative Tami Eller, UAA/CHD, Family Services Training Center, Lead Behavioral Health Training Coordinator Brenda Ursel, M.S. Lead Behavioral Health Training Coordinator	
2:00 – 4:00 pm	**Alaska Native Cultural Overview Presentation**
Ann Hansell Program Manager, Community Health Services Administration, Alaska Native Tribal Health Consortium	
4:00 – 4:15 pm	**Closing Remarks**
Yvette Stratton, RN, CCM Executive Director, Care Management, Comagine Health	

Housekeeping

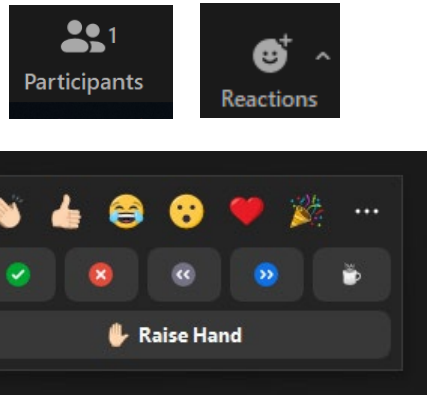
Use the **Chat** as a backchannel for questions and comments & to participate in activities



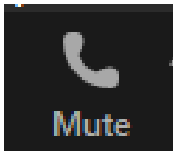
Remain on **mute** when you're not speaking. Unmute yourself only when you want to speak.



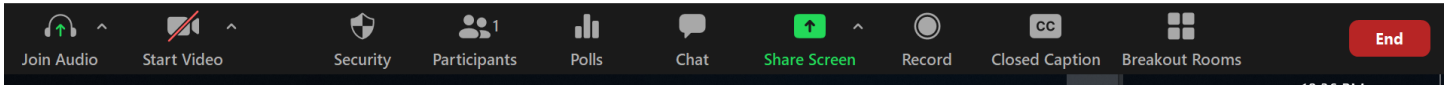
Click on **Participants** or **Reactions** to share reactions



If you are joining us **by phone**, please **dial *6 to mute / unmute.**



Note: This session is being recorded. The recording and slide deck will soon be posted to the Comagine Health website.



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Opening Remarks

Yvette Stratton, RN, BSN, CCM
Associate Vice President, Care Management, Comagine Health

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State Initiatives and Updates

Lynne Keilman-Cruz

Director, Division of Health Care Services

Comagine Health

State Initiatives and Behavioral Health Updates

Amaris Rosario

Interim Deputy Director, Division of Behavioral Health

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Crisis Now Initiatives and Updates

Eric Boyer

Senior Program Officer, Alaska Mental Health Trust Authority

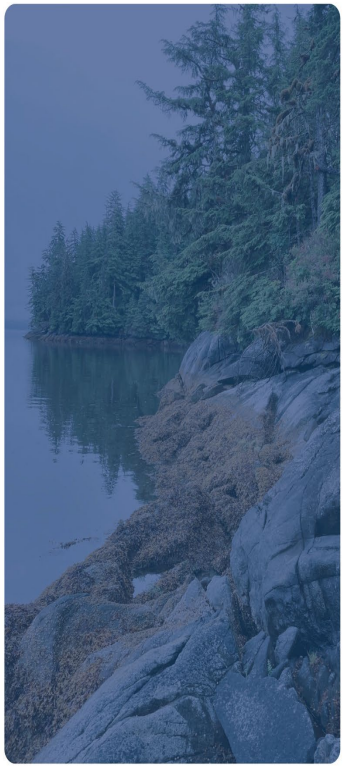
IMPLEMENTING A BEHAVIORAL HEALTH CRISIS SYSTEM OF CARE (2018-2026)









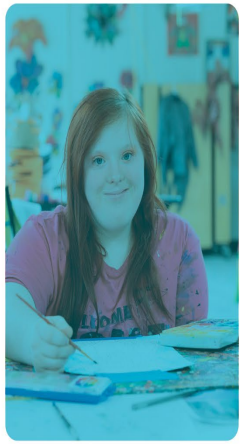




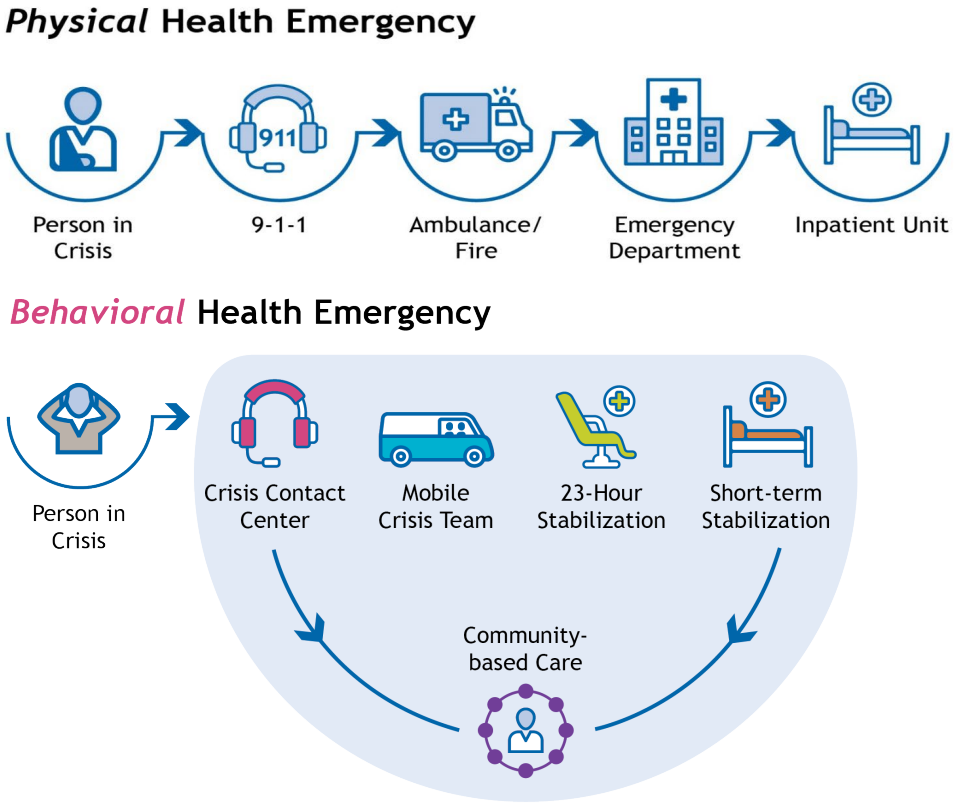


Trust

Alaska Mental Health Trust Authority



GOAL: Design and implement a behavioral health crisis response system analogous to the physical health system.



Why is Crisis Now needed in Alaska?

A well-coordinated behavioral health crisis continuum of care keeps individuals in their communities in the least restrictive environment.

2x People with a behavioral health diagnosis are 2x as likely to have a 12+ hour stay and more than 2x likely to stay more than 24 hours in the Emergency Department compared to those without a behavioral health diagnosis.[1]

$$ Alcohol misuse costs the state over $2 billion in 2018 in productivity, traffic collisions, health care, social services and criminal justice services.[2]

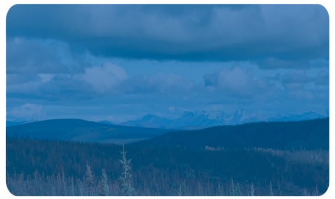
Fragmented care coordination for youth and adults.[3] [4]

High rates of individuals with behavioral health conditions incarcerated or engaged in the criminal justice system.[5]

Inability to access timely and appropriate behavioral health stabilization and treatment services.[6]

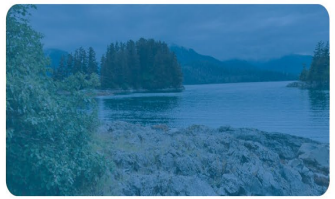
Cycling through corrections, courts, psychiatric hopsitalization, and emergency services.[7]

[1] ASHNAA Acute BH Improvement Project, 2019; [2] The Economic Costs of Alcohol Misuse In Alaska, 2019; [3] ASHNAA Acute Behavioral Health Improvement Project, 2019;
[4] AHHA Child and Adolescent Behavioral Healthcare Improvement Project, 2022; [5] Trust Beneficiaries in Alaska's Department of Corrections, 2014;
[6] HB 172 Psychiatric Patient Rights in Alaska, 2023; [7] Forensic Psychiatric Hospital Feasibility Study, 2019





Alaska's Behavioral Health Crisis Response Innovation Timeline



Key milestones in the implementation of a coordinated, connected system of behavioral health crisis care in Alaska.

2018

Federal approval (CMS) for SUD component of 1115 Medicaid Waiver

Initial conversations about Crisis Now framework in Alaska

Behavioral Health Improvement Project focuses on psychiatric boarding in emergency departments [Pub.A]

2019

Forensic Psychiatric Hospital Feasibility Study completed [Pub.B]

Federal approval (CMS) for behavioral health component of 1115 Medicaid Waiver

RI International conducts Crisis Now implementation readiness assessment in Anchorage, Mat-Su and Fairbanks [Pub.C]

Statewide convening on behavioral health crisis continuum

First site visit to Arizona to see Crisis Now in action

2020

Community planning workgroups convened in Anchorage, Fairbanks and Mat-Su

Concept-level pro formas developed for crisis services

SB 120 amends Title 47 to include crisis stabilization centers as locations for emergency detention

Settlement agreement with Disability Law Center identifies Crisis Now as a systems improvement initiative

2021

Crisis Now community coordinator positions funded in Fairbanks and Mat-Su

Mobile crisis teams launch in Anchorage and Fairbanks

2022

HB 172 signed into law

988 goes live nationwide

Mat-Su dispatch agency begins transferring behavioral health calls to Careline

Ketchikan Crisis Now community coordinator position funded and community planning begins

Five organizations across the state exploring 23-hour stabilization and/or short-term stabilization services

Planning begins in Kotzebue, Juneau, Copper Basin and Unalaska

Crisis Now Core Principles and Practices webinars begin

Child and Adolescent Behavioral Healthcare Improvement Project completed [Pub.D]

US Department of Justice report on Alaska's behavioral health system for children released [Pub.E]

2023

Careline launches law enforcement backline. Anchorage Police Department begins transferring calls

Mobile crisis team launches in Mat-Su

Ketchikan City Council approved positions for Mobile Integrated Healthcare program

Juneau community planning workgroup begins

Groundbreaking for Providence Crisis Stabilization Center

State of Alaska hosts Behavioral Health Roadmap meetings across the state

HB 172 Psychiatric Patient Rights Report submitted to the State Legislature [Pub.F]

2024

Groundbreaking for Southcentral Foundation Crisis Stabilization Center

Bartlett Regional Hospital and Capital City Fire and Rescue partner to launch MCT in Juneau

Trust hosts Crisis Now convening

Alaska Behavioral Health launches Mobile Outreach for Children and Families program in Fairbanks

Volunteers of America launches Rapid Response team

Anchorage Fire Department MCT pilots 24/7 response and is codified as an essential service

Milliman completes assessment of Alaska's behavioral health crisis continuum of care [Pub.G]

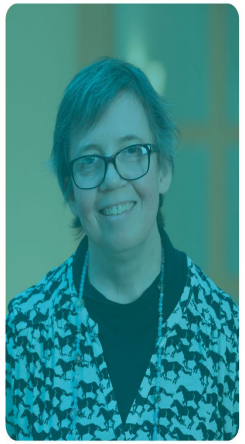
Ketchikan launches Mobile Integrated Health program

Central Peninsula Hospital begins mobile crisis response planning

Fairbanks MCT begins response to calls when requested by Alaska State Troopers

Department of Health begins Medicaid Rate Review project

Mat-Su MCT expands their service area



Publications

A. Behavioral Health Improvement Project
B. Forensic Psychiatric Hospital Feasibility Study
C. Crisis Now implementation readiness assessment
D. Child and Adolescent Behavioral Healthcare Improvement Project
E. US Department of Justice report on Alaska's behavioral health system for children
F. HB 172 Psychiatric Patient Rights Report
G. Assessment of Alaska's Behavioral Health Crisis Services Continuum of Care

Trust Investments: Calendar Years 2021—2025

Contact Center
Total investment: $468,519

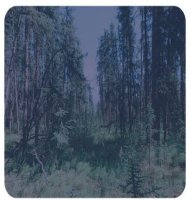
Mobile Response
Total investment: $8,737,761

Place-Based Crisis Services
Total investment: $7,608,913

Community Coordination
Total investment: $2,116,303

System Support
Total investment: $1,274,339

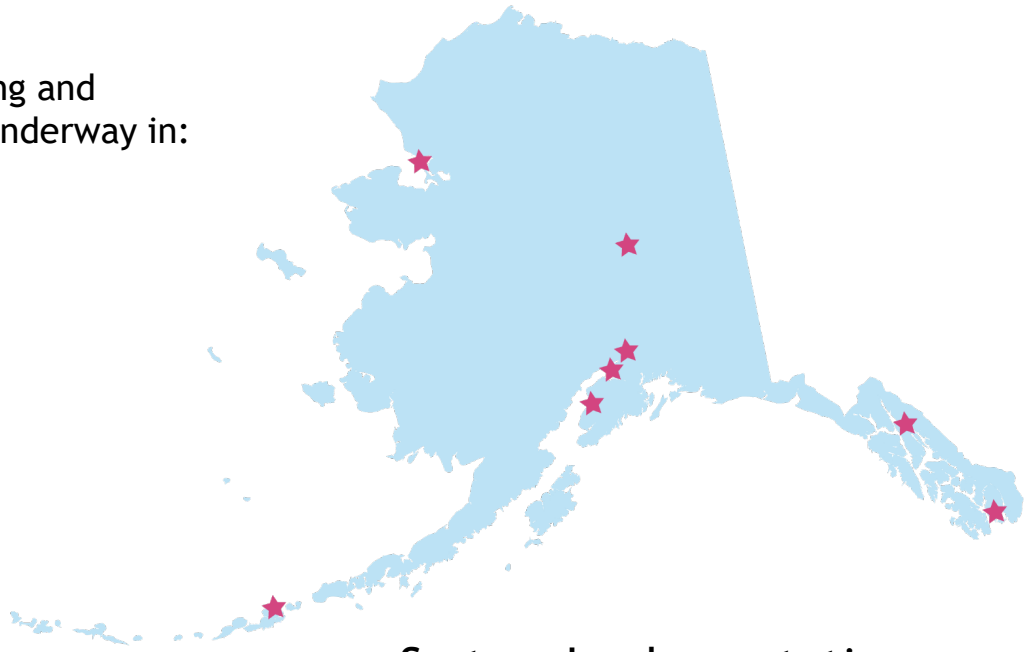
Additionally, Trust funding supports Alaska partner participation in crisis system immersion trips to Arizona, with 15 trips supported between 2018-2024.



Crisis Now Implementation At a Glance

Crisis Now planning and implementation underway in:

Anchorage
Mat-Su
Fairbanks
Juneau
Ketchikan
Central Kenai
Nenana
Kotzebue
Unalaska

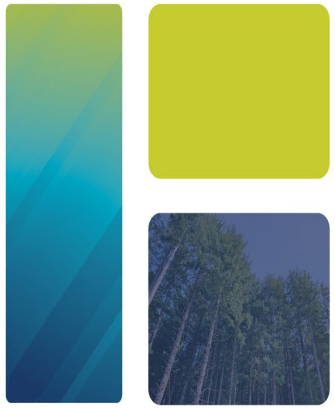


System Implementation

- House Bill 172 signed into law in July 2022
- 988 implemented nationwide in July 2022
- Medicaid 1115 waiver implementation ongoing
- Subacute mental health facility regulations finalized







Community Adaptations

Key:
Green text = operational
Black- in process







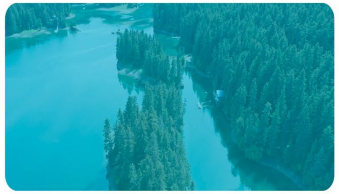
Community	Contact Center*	Mobile Response	23-Hour	Short-Term	DES or DET Beds
Anchorage	911 transfers calls to Careline	Clinician + EMT/paramedic Clinician + Law Enforcement	Voluntary and involuntary/SCF, Providence, AKBH- summer/fall 2026	Voluntary and involuntary/SCF and Providence- summer/fall 2026	Yes
Soldotna	911 transfers calls to Careline	Peer + Peer/Telehealth Clinician	TBD	TBD	No
Fairbanks	911 transfers calls to Careline	Clinician + Peer &	Voluntary only/AKBH	Voluntary only	Yes
Juneau	911 transfers calls to Careline	MIH model; EMT + Clinician	TBD	TBD	Yes
Ketchikan	Careline	MIH model	TBD	TBD	Yes
Kotzebue	Careline	TBD	EmPATH- 2026/2027	TBD	No
Mat-Su	911 transfers calls to Careline	Clinician + Peer &	Peer living room model	Voluntary only	Yes
Unalaska	Careline		Voluntary- fall 2026		No

To learn more or get involved:

- Learn more about the initiative on the Trust's website
- Sign up to receive quarterly newsletters and invitations to webinars on best practices, workforce development and other key implementation areas – Email megan@agnewbeck.com
- Contact the Trust to learn about technical assistance and funding available to support development of crisis and post-crisis services – Email eric.boyer@alaska.gov










Thank You

Questions?








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Break

We will resume at 11 am AKST

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Understanding and Addressing High Healthcare Utilization Among Medicaid Recipients

Dr. Sarah McCutcheon, MD, FAPA, BCPA

Regional Medical Director, Care Management, Comagine Health

Outline

1. Case vignette

2. What is high healthcare utilization (HHU)?

3. How can we address HHU?

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Section 1: Case Vignette

Meet William

- 48-year-old Alaska Native male
- Medicaid recipient
- Unemployed
- Transitional housing in Fairbanks
- Limited transportation



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William's Medical History



- Diabetes Mellitus, Type 2
- Hypertension
- COPD
- Chronic low back pain
- Bipolar I disorder
- Alcohol use disorder

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William's Current Clinical Status

- Chronic physical health conditions: poorly controlled
  - HbA1c: 11.4%
  - Blood pressures: 150s-160s/90s mmHg
  - Smoking 1-2 packs/day
  - Moderate depressive symptoms (PHQ-9 score of 12)
  - Recent alcohol relapse
- Medication adherence: ~40%
- No PCP or behavioral health provider

PCP: Primary Care Provider
PHQ-9: Patient Health Questionnaire-9

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William's 12 Month Hospital Utilization Pattern



HYPERGLYCEMIA (2 ADMISSIONS)



COPD EXACERBATION (ICU STAY)



ALCOHOL WITHDRAWAL (1 ADMISSION)



CELLULITIS (2 ED VISITS)



CHEST PAIN (2 ER VISITS)



FROSTBITE (1 ER VISIT)

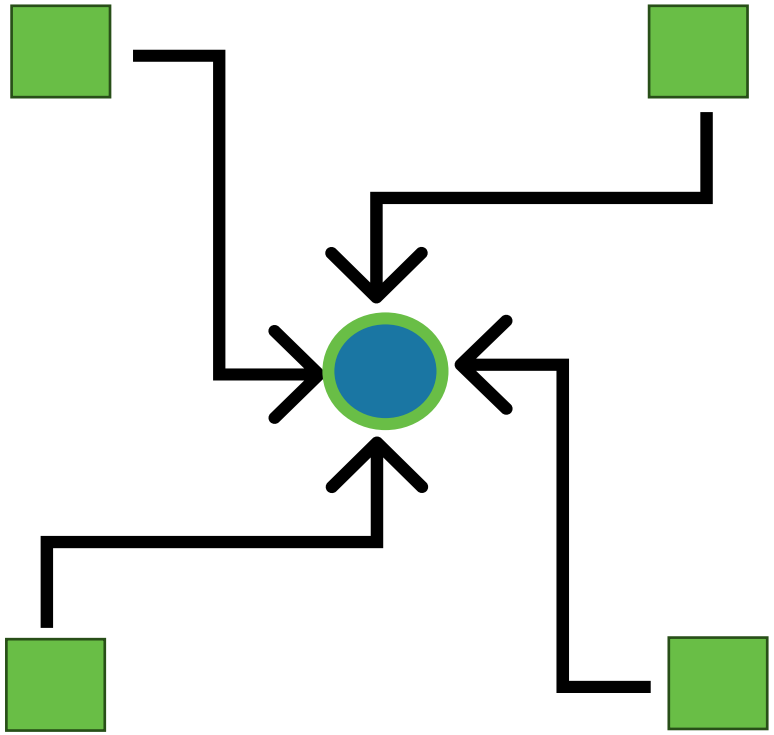


MEDICATION REFILLS (2 ER VISITS)



FALL WITH RIB FRACTURES (1 ER VISIT)

What are the Root Causes of William's HHU?



Physical Health Causes



- Several poorly controlled chronic health conditions
  - COPD, diabetes, and hypertension
- These conditions interact
- Necessary treatments worsen his chronic health conditions

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Physical Health Causes

Physiologic instability → episodic health crises → **hospital-based care**

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Behavioral Health (BH) Causes

- Mood episodes and heavy alcohol use make it very difficult to-
  - Monitor blood glucose
  - Prepare healthy meals
  - Adhere to treatment
- Psychological factors worsen clinical outcomes



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BH Causes

Exacerbation of BH condition → poor self-management → episodic health crises → **hospital-based care**

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Social Causes

- Adverse childhood experiences
- Financial strain
- Food insecurity
- Housing insecurity
- Limited social supports

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Geographic Causes

- Provider scarcity
- Technology challenges
- Transportation limitations
- Weather challenges

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Social Causes

- Adverse childhood experiences
- Financial strain
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Geographic Causes

- Provider scarcity
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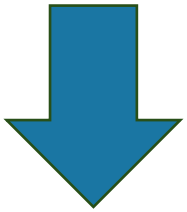
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Social stressors → chronic stress physiology + disrupted health management → episodic health crises → **hospital-based care**

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HHU is Predictable

Physical health causes
Behavioral health causes
Social causes
Geographic causes



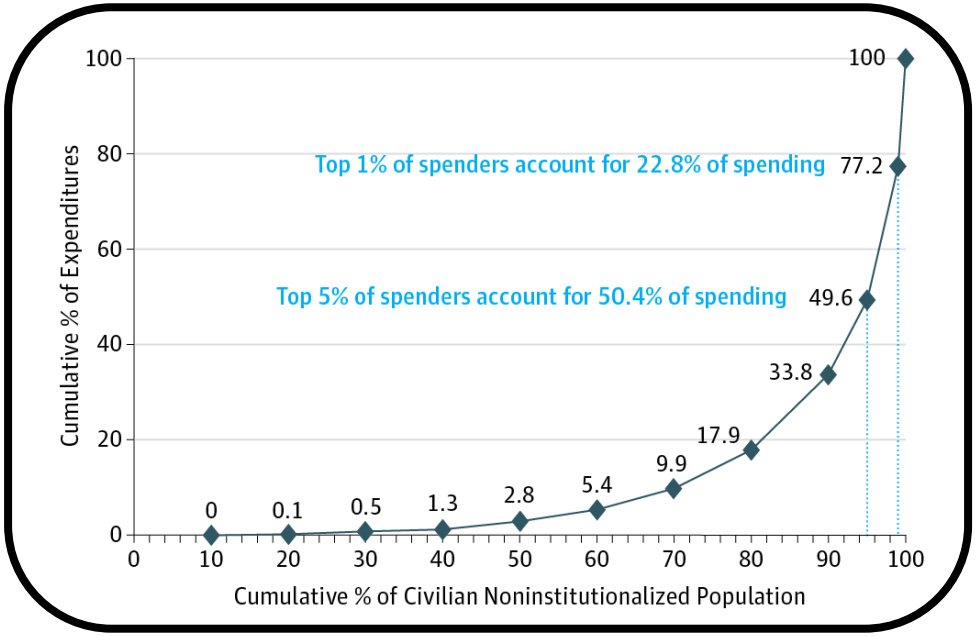
A predictable conversion of chronic illness into episodic crises and HHU

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Section 2: What is high healthcare utilization (HHU)?

Healthcare Costs

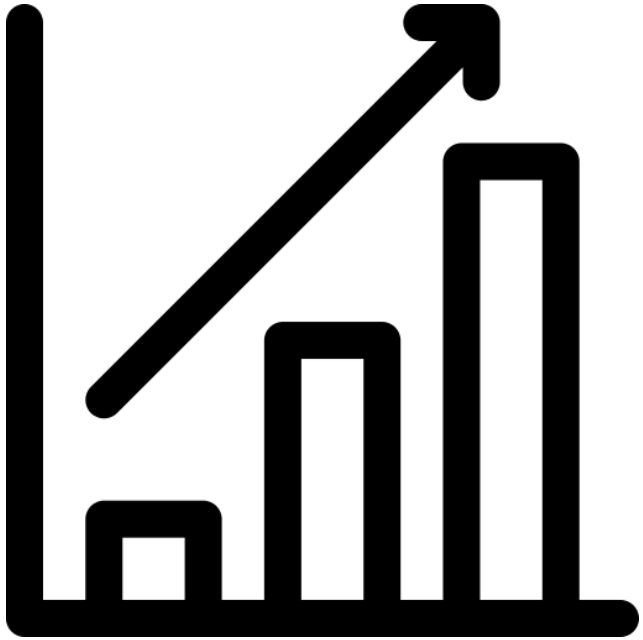
- Top 5% patients → ~50% of costs
  - Top 1% → ~25% of costs
- Pattern has been stable over time
- Disproportionately concentrated in Medicaid population



Dzau, V., et al. *JAMA*. 2017

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What Drives HHU and Costs?

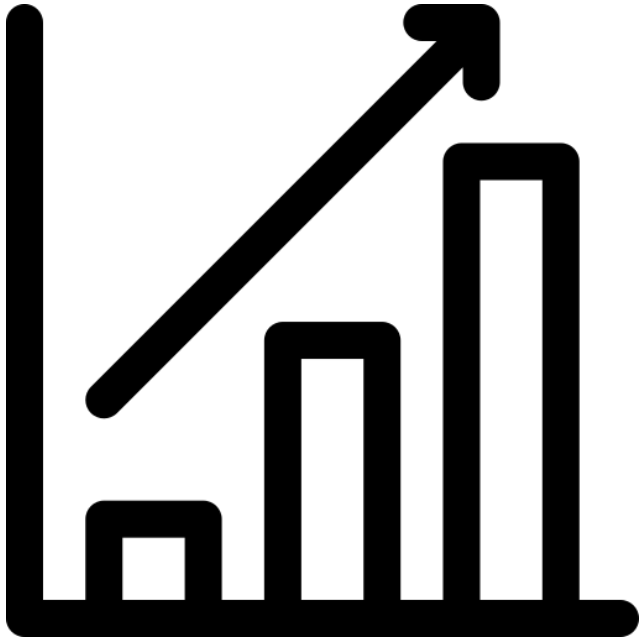


- Number and severity of comorbid conditions
- Chronic health conditions
- BH illness
- Social instability
- Prior HHU

Berkman, et al., *Annals of Internal Medicine*. 2022

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What Drives HHU and Costs?



- Number and severity of comorbid conditions
- Chronic health conditions
- BH illness
- Social instability
- Prior HHU

The **combination** of these factors has the biggest impact.

Berkman, et al., *Annals of Internal Medicine*. 2022

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BH Conditions Intensify Utilization



74% of spending in patients with BH diagnoses is for physical health services (1)



Patients with serious mental illness are 84% more likely to be admitted for physical health conditions (2)

1)Ward et al., *Community Mental Health*. 2017
2)Ronaldson et al., *PLOS ONE,* 2000.

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Section 3: How can we address HHU?

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Care Models that Reduce HHU

Care Model
Transitional Care Model (TrCM)
Clinical Case Management (CCM)
Intensive Case Management (ICM)
Targeted Case Management (TCM)
Assertive Community Treatment (ACT)

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Transitional Care Models (TrCM)

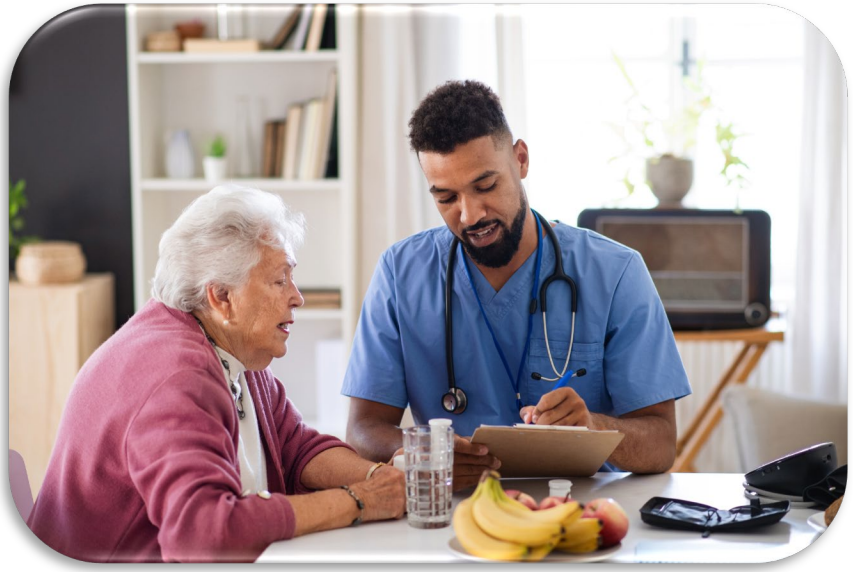
- 7–30 days post-discharge
- Medication reconciliation
- Symptom monitoring
- Schedule rapid follow-up
- Care coordination
- Hand off to **longitudinal care provider** is critical to sustain gains



Brom H., *BMJ Open Quality*, 2022

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Clinical Case Management (CCM): A Foundational Model



- Longitudinal, therapeutic relationship
- Clinically trained case manager
- Responsibility for continuity and follow-through
- Address and integrate medical, behavioral, and social care needs

Case Management Society of America (CMSA)

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Core Elements of CCM

- Clinical engagement and therapeutic alliance
- Comprehensive biopsychosocial assessment
- Active care coordination
- Ongoing monitoring and follow-up
- Advocacy and system navigation

Case Management Society of America (CMSA)

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Why CCM Works for High Utilizers



- Trust enables engagement
- Engagement enables coordination
- Coordination enables stability

Hudon, et al., *Annals of Family Medicine*, 2020

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Intensive Case Management (ICM)

- Enhanced services compared to CCM
- Smaller caseloads
- More proactive outreach
- Community-based care
- Patients with complex physical health and BH needs

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Targeted Case Management (TCM)

- CCM applied to a specific high-risk subgroup
- Smaller caseloads, higher intensity
- Time-limited but focused

Case Management Society of America (CMSA)

Targeted Case Management (TCM)

- CCM applied to a specific high-risk subgroup
- Smaller caseloads, higher intensity
- Time-limited but focused

Targeting is a **resource allocation** decision

Case Management Society of America (CMSA)

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Assertive Community Treatment (ACT)

- Multidisciplinary team
- Provides 24/7 support, including crisis interventions
- Promotes treatment engagement
- Responsibility for care coordination
- Address and integrate medical, behavioral, and social care needs

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Assertive Community Treatment (ACT)

Highest-intensity model for serious mental illness (SMI)

- Multidisciplinary team
- Provides 24/7 support, including crisis interventions
- Promotes treatment engagement
- Responsibility for care coordination
- Address and integrate medical, behavioral, and social care needs

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ACT's Impact

- Increases treatment engagement
- Fewer ER visits
- Reduced psychiatric hospitalizations
- Improved housing stability



Coldwell C., et al., *American Journal of Psychiatry*, 2007

Dieterich M., et al., *Cochrane Review*, 2017

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Care Models that Reduce HHU

Care Model	Key Defining Attribute
Transitional Care Model (TrCM)	Short-term, post-discharge risk reduction
Clinical Case Management (CCM)	Longitudinal coordination & therapeutic relationship
Intensive Case Management (ICM)	Small caseloads, proactive outreach, community-based
Targeted Case Management (TCM)	CCM or ICM applied to defined high-risk periods
Assertive Community Treatment (ACT)	Highest-intensity, 24/7 team-based care for patients with serious mental illness (SMI)

Conclusions about HHU

- High utilization is predictable, not random
- Driven by medical + behavioral + social + geographic factors
- Models must be designed for multiple medical comorbidities, especially BH
- Several models have been shown to reduce HHU among Medicaid beneficiaries

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What Would Change for William with Targeted ICM?

- Continuous, proactive engagement
- Integrated management of physical health and BH conditions
- Reduce social needs
- Reduction in crisis-driven care
- Improved function and stability over time



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Questions?

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Lunch Break

We will resume at 1 pm AKST

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AKTC FSTC Training

Niki Knowlton, LCSW, MPH, Behavioral Health Training Coordinator for the University of Alaska, Center for Human Development, Alaska Training Cooperative

Tami Eller, UAA/CHD, Family Services Training Center, Lead Behavioral Health Training Coordinator

Brenda Ursel, MS, Lead Behavioral Health Training Coordinator

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Alaska Native Cultural Overview Presentation

Ann Hansell

Program Manager, Community Health Services Administration, Alaska Native Tribal Health Consortium

Comagine Health

Closing Remarks – Day One

Yvette Stratton, RN, BSN, CCM
Associate Vice President, Care Management, Comagine Health

Please complete the survey

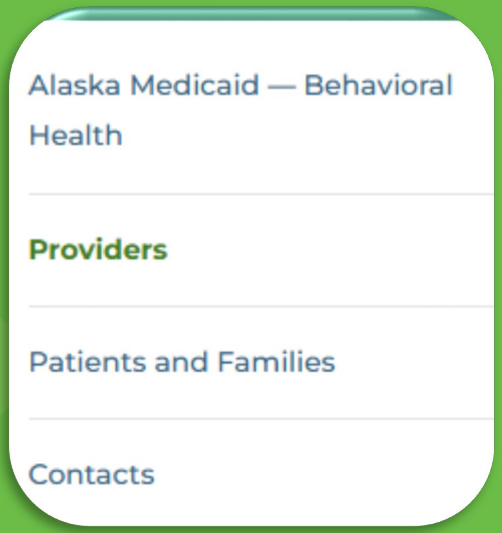
Link: https://uaa.co1.qualtrics.com/jfe/form/SV_5dxge7MqFfLAp4a

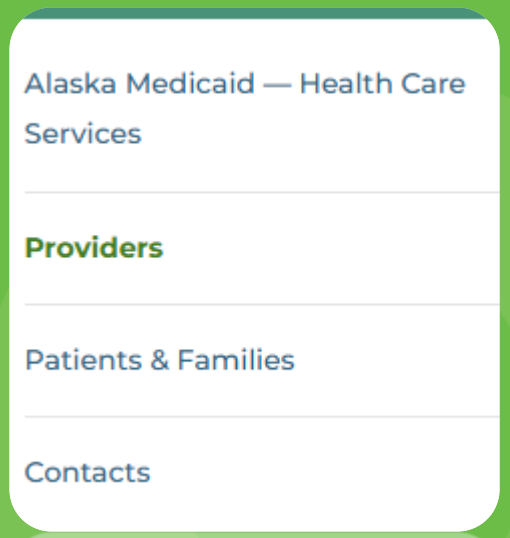
QR Code:

- The survey only needs to be completed once.
- The evaluation and CE claiming window is **open for two weeks only** following the conference.
- This is a **two-step process:**
  1. Complete the anonymous event evaluation.
  2. Complete the CE claim and certificate portion, which is not anonymous.

Thank you for attending!

A recording of the presentation will be available on the Comagine Health website under Programs, Alaska Medicaid Behavioral Health, and Alaska Medicaid-Division of Health Care Services. Click on the Provider link for Provider Resources.





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