Mountain View Health Services

Strategic Planning Support + Financial Modeling Summary

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Project Overview

Mountain View Health Services (MTVHS) is a non-profit Urgent Care clinic located in the Mountain View neighborhood of Anchorage, Alaska. MTVHS brings together a close-knit staff who are dedicated to the work they do and the community they serve. In 2022, the clinic added two behavioral health clinicians to address unmet patient needs. The same year, MTVHS acquired the adjacent space in their building and needed to determine the best use for that space. MTVHS obtained funds from the Alaska Mental Health Trust Authority and contracted Agnew::Beck to assist with visioning, financial modeling, and strategic planning. The goal of these efforts was to find effective ways for the clinic to build sustainable behavioral health programs internally and to identify opportunities for partnerships with existing service providers and initiatives.

Some of the priorities identified prior to the contract with Agnew::Beck include:

- Integrate urgent care with primary care and behavioral health, which includes both mental health and substance misuse services to deliver a whole person care model.
- Collaborate with the implementation of the Crisis Now framework in Anchorage.
- Increase access to same-day behavioral health visits and medication management.
- Provide follow-up care from a crisis episode and a referral source for crisis stabilization services.
- Investigate offering a clubhouse model of care for people with serious and persistent mental illness (SPMI).

To identify the most effective role for MTVHS, Agnew::Beck facilitated a series of visioning and strategic planning sessions, researched the clubhouse model and behavioral health billing options, and joined MTVHS in a series of community partner meetings. These meetings illuminated a range of services already available in the community or in development, and established MTVHS as an enthusiastic partner for mutual referrals and potentially piloting new programs. Using information learned through these activities, MTVHS identified specific services lines to explore in financial modeling. The resulting financial model and three-year strategic plan for the organization are attached. Key take-aways from strategic planning, behavioral health program visioning, financial modeling, and community partner meetings are included below.

Strategic Planning

MTVHS Medical Director Dr. Jon VanRavenswaay's motto from the outset of the process was to "stabilize the core". While MTVHS is an ambitious organization that is highly motivated to address needs as they encounter them, their new strategic plan focuses on supporting foundational urgent care services and adding behavioral health crisis and outpatient services to their suite of programs. A core theme of the strategic planning process was to balance the ways in which the MTVHS team wants to support their community with the awareness of its role in a larger system of care.

With an appreciation of their organizational needs, MTVHS and Agnew::Beck worked together to understand what resources were available or in development in and around the Mountain View community as well as identified what sustainable growth might look like for MTVHS. The final strategic plan identifies six long-term goals:

1. Provide low-barrier access to quality, whole-person care.
2. Be a trusted health care provider in Mountain View that welcomes all.

3. Be an employer of choice for quality staff who share our mission and vision.
4. Manage a compliant and financially sustainable health care practice.
5. Maintain robust community partnerships and engagement.
6. Improve and maintain safe, welcoming, and efficient facilities.

MTVHS experienced a prolonged season of change. Since 2019 they converted to a non-profit model, operated and closed a grant-funded COVID vaccination and testing clinic, expanded into behavioral healthcare, explored bringing on a full-time Primary Care physician, and weathered the same COVID-related changes to community need, funding, staffing, safety, and relationships with community partners that all healthcare providers experienced over the past three years. As the strategic plan took shape and current objectives were considered against longer term priorities, it became clear that Dr. VanRavenswaay's focus on the core was well timed. While MTVHS remains open to expanding their services, the current strategic plan focuses on establishing institutional knowledge through protocols and policies and strengthening relationships with staff and community partners.

Strategic planning helped MTVHS identify the next steps for growth that were most feasible and prioritize those over other potential goals, such as incorporating a pharmacy or pursuing certification as CBHC. That prioritization resulted in more focus on defining objectives for more immediately feasible goals, such as negotiating a shared cost structure for the renovation of their new space and determining whether a community partner's medication management program can be incorporated into the MTVHS business model.

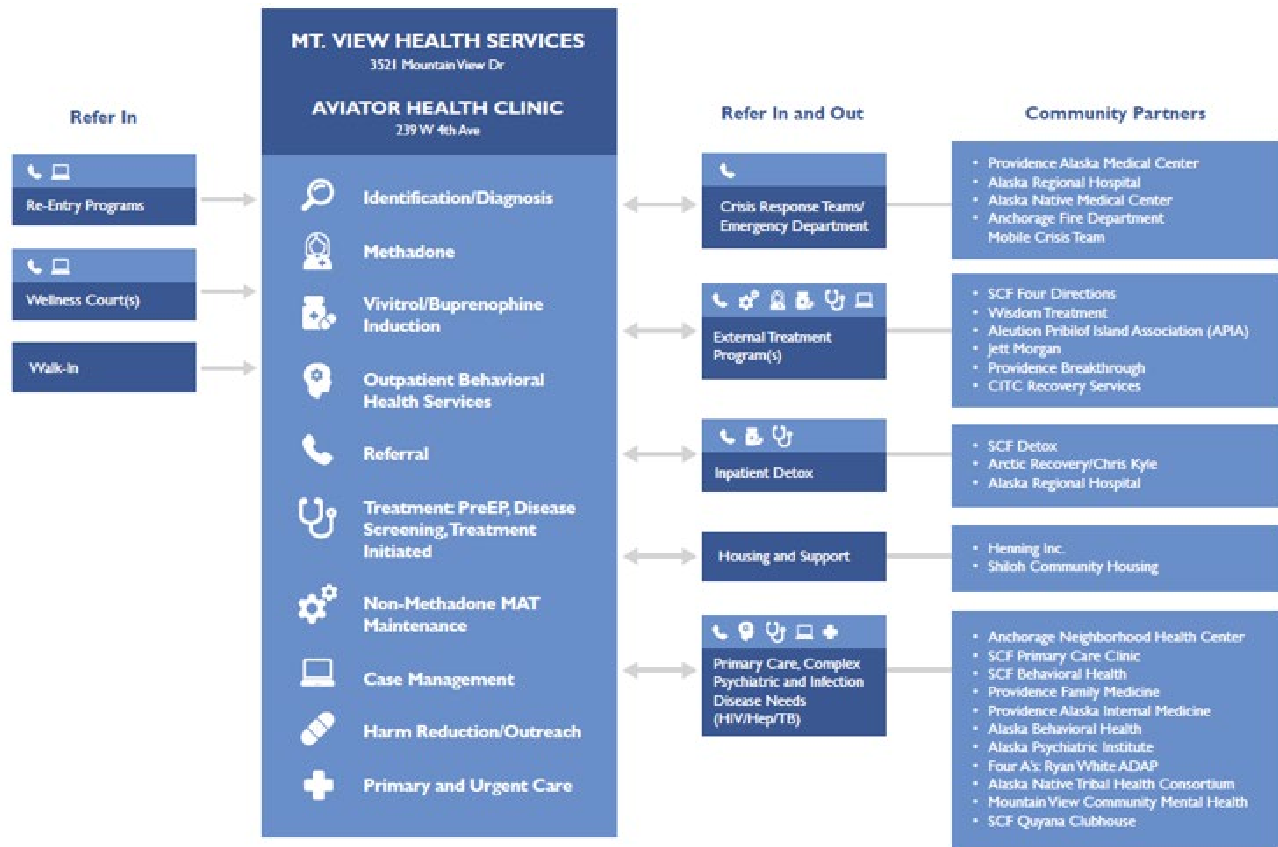
Program and Services Visioning

As part of this project, Agnew::Beck met with the MTVHS team to understand who they are as an organization and what they most value about the work they do. The initial planning meeting, held in November 2022, identified three key themes:

- MTVHS strives to be a provider that vulnerable community members trust.
- MTVHS prioritizes access and integration so those who come through the door will be cared for.
- MTVHS seeks to address inequities in health care access and outcomes and brings a multi-disciplinary understanding of the role they play to build individual and community well-being.

Through shared decision-making and supporting staff to pursue their passions, MTVHS developed an ambitious list of possible new programs, services and ideas for exploration. MTVHS understands their role as part of a larger system of care. To better appreciate the web of referrals that allows patients to receive the care that they need, the team explored MTVHS's "spoke-and-wheel" list of community partner relationships (see Figure 1: Referral Network). This robust network demonstrates that MTVHS already plays a vital role in a continuum of care, and they partner widely to make sure patients receive appropriate care. Understanding the most effective mix of services for MTVHS to provide requires understanding their relationships with community partners. As MTVHS considered behavioral health options, they knew they would need to rekindle pre-COVID connections and forge new ones.

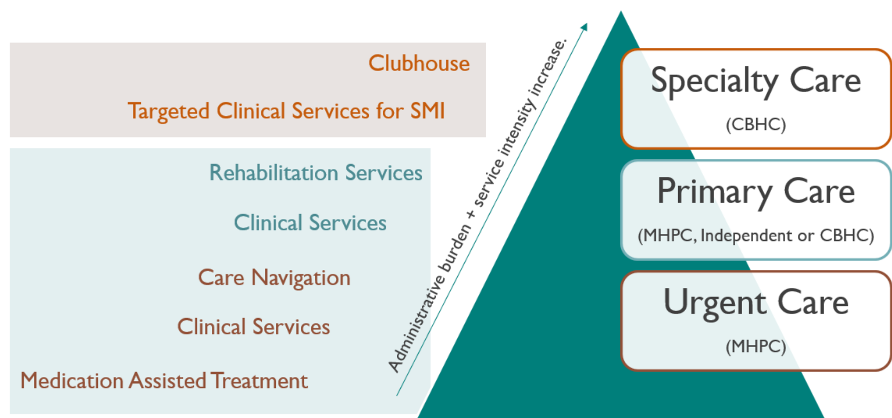
Figure 1: Referral Network



Behavioral Health Levels of Care and Billing Models

Figure 2: Levels of Care presents a range of behavioral health options considered as part of the visioning process. The pyramid represents fewer individuals served as services become more intensive while also acknowledging that administrative burden increases for both staff and the client.

Figure 2: Levels of Care



Agnew::Beck presented three possible billing models, the service descriptions available under each, and MTVHS's current staffing and capacity (see Figure 3: Billing Models and Services). In this figure, initial contact with the client is represented in the left column and darker colors indicate the commitment of the client's time before they can begin treatment. For clients who cannot initially engage in a full assessment and treatment plan, Crisis Intervention services can offer immediate services until the client is able to complete the assessment and treatment planning process. Moving down the columns, the figure presents newly available services under each billing model in bold font.

Figure 3: Billing Models and Services

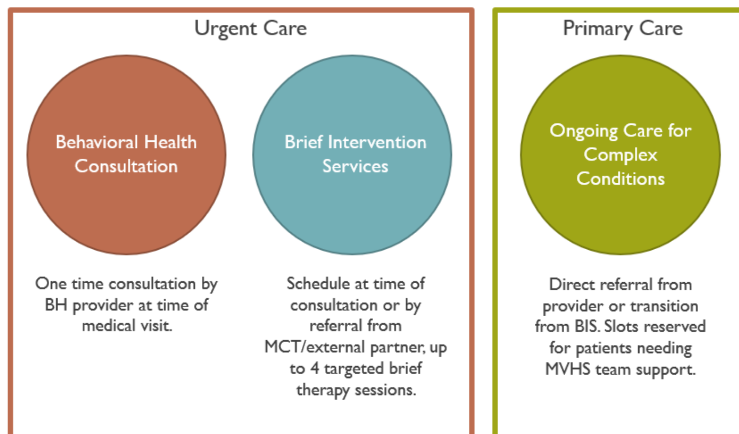
	Walk-in	Assessment	Treatment Plan	Services	Notes
Licensed Ind. Provider	Screening, Brief interventions and Referral to Treatment (SBIRT)	Integrated Behavioral Health Assessment (IBHA)	[non-billable]	Psychotherapy	Cannot provide crisis care Limited SUD support No peer staffing options No unlicensed provider options Services not billable until Assessment and Treatment Plan complete
MHPC Model	**Crisis Intervention** (2 week treatment plan) →			Psychotherapy **Pharmacological Management**	Must be billed separately from medical claims Crisis plans can be renewed Tx plan can be based on Psychiatric Assessment if Dx provided
	Screening, Brief interventions and Referral to Treatment (SBIRT)	Integrated Behavioral Health Assessment (IBHA) **Psychiatric Assessment**	[nonbillable]		
CBHC/ 1115 Waiver	Crisis Intervention (2 week treatment plan) →			Psychotherapy Pharmacological Management **Community Recovery Support Services** **Intensive Case Management**	Requires accreditation through Joint Commission, CARF, or Counsel on Accreditation (COA) Providing staff will need QAP credentials, including tracking for those on 3 year provisional credentials Crisis plans can support Peer Support Staff
	Screening, Brief interventions and Referral to Treatment (SBIRT)	Integrated Behavioral Health Assessment (IBHA) Psychiatric Assessment	**Treatment Plan Development and Review**		

MTVHS has two master's level behavioral health clinicians who are working toward licensure. The lowest administrative lift for MTVHS would be for those clinicians to begin billing assessment and psychotherapy as independent providers. However, MTVHS is already approved to bill as a Mental Health Physician Clinic (MHPC). Billing as independent providers allows for fewer services and pursuing approval for a Community Behavioral Health Clinic (CBHC) requires more administrative lift. Billing as a MHPC will allow for billing sooner while providing a wider range of services than the independent provider model. MTVHS will refer to community partners for CBHC services.

Crisis and Outpatient Behavioral Health Services

Consultation, Crisis Care and Outpatient Therapy

Figure 4: Urgent and Ongoing Behavioral Health Services



To ensure integration with physical health services, MTVHS determined that behavioral health staff will be available for consultations as a non-billable, brief service. If behavioral health staff determine that behavioral health services are appropriate, they will then provide either Screening, Brief Intervention and Referral to Treatment (SBIRT) or crisis intervention. The goal of brief intervention services can either be to help the person stabilize a short-term crisis or to engage in a sustained treatment program. These services are

offered until the short-term crisis is stabilized or while the individual person is awaiting admission into an outpatient program. MTVHS will also provide outpatient behavioral health with staff carrying regular caseloads, providing assessments and psychotherapy under a treatment plan. Figure 4: Urgent and Ongoing Behavioral Health Services represents these two programs as boxes with the services available to clients within these programs represented in circles. In early conversations, the physical health terms "Urgent" and "Primary" were also used for describing MTVHS behavioral health services. However, using the behavioral health terms "Crisis" and "Outpatient" provided more clarity.

Medication Management

Mountain View Health Services partner Delphine Atu-Tetuh, Advanced Nurse Practitioner (ANP), of Mountain View Community Mental Health Services, participated in visioning sessions with MTVHS staff and recently acquired office space within the clinic. Visioning outpatient behavioral health services for MTVHS included discussion of how to incorporate an ANP (in partnership with Mountain View Community Mental Health or by direct employment) to provide ongoing medication management services. The ANP will provide two primary services: psychiatric assessments and ongoing medication management. Medication management sessions are billed as pharmacological management under the ANP schedule and as comprehensive medication services under the MHPC schedule. Communication with the Medicaid Provider Assistance Support Staff (MPASS) unit confirmed the comparability of the differently named services on the two fee schedules. A pdf copy of this email exchange is attached. Medicaid rates for psychiatric assessments and medication management under the MHPC schedule are higher than what an independent ANP can bill for these same services.

Specialty Care: Exploring the Clubhouse Model

Part of the impetus for this strategic planning process was MTVHS's interest in the Clubhouse International model. Clubhouse International describes their model as "local community centers that provide members with opportunities to build long-term relationship that, in turn, support them in obtaining employment, education and housing."[1] Clubhouses provide structured daily schedules to help members to practice job readiness and transitional employment through community partners. Consensus-based decision making ensures the clubhouse continues to serve member needs and provides opportunities for leadership development. Social connection and access to resources and supports are the other cornerstones of the clubhouse model.

MTVHS serves individuals who experience SPMI and recognized that while many of these individuals have supportive housing already, what they need is a safe place to go and activities during the day. As part of program visioning, the team explored MTVHS's ideas for what such a service might look like and identified community partners who might collaborate to develop a clubhouse-style center in Mountain View.

In visits with community partners, the team learned that three local organizations provide daytime activities. Southcentral Foundation's Quyana Clubhouse offers clinically driven wrap-around care that includes rehabilitation, psychotherapy, medical care and case management. For those who would benefit from a more person-directed approach, the Alaska Mental Health Consumer Web offers recovery-based engagement that provides an internet café, social space, peer-led classes and mentoring. Cook Inlet Tribal Council (CITC) offers a wide range of levels of care and wrap-around services and their newly launched Welcome Center provides navigation to those services, including a Recovery Services department that maintains an open-door social space throughout the day. The Welcome Center and other CITC services are located proximal to the

[1] Clubhouse International. "What We Do." https://clubhouse-intl.org/what-we-do/what-clubhouses-do/

Mountain View neighborhood and in some circumstances, provide transportation to increase accessibility of services.

Financial Modeling

The model is a tool for financial decision-making to determine which new programs are the best fit based on MTVHS's current capacity. Four potential lines of service were modeled: primary physical health care, behavioral health medication management, behavioral health outpatient, and behavioral health crisis. Medication management was modeled both for an independent ANP and for billing under a MHPC.

Informing the model is the clinic's payer mix, which is approximately 72% Medicaid, five percent self-pay, and eight percent private insurance and Medicare, and the remainder of clients non-resourced. It accepts all private and public health coverage other than United Health. The clinic receives some grant funds and donations. The clinic uses Athena Health for its EHR. A 25% tax and benefit rate is included. Expense assumptions do not include additional costs such as facilities, supplies and administrative overhead.

In the course of this process, MTVHS determined that a single primary care physician requires too many additional support staff to fit into MTVHS's current clinic. Via Medicaid, medication management is compensated at a higher rate through an MHPC. The proposed program suite in this financial model (in green below) totals revenue and staffing expenses for medication management, behavioral health outpatient and behavioral health crisis, all billed through the MHPC billing model. Figure 5: Net Revenue for Proposed Programs shows the results of the financial modeling by program.

Figure 5: Net Revenue for Proposed Programs

Physical Primary	BH Medication Management		BH Outpatient	BH Crisis	Proposed Program Suite
Program	Billed ANP	Billed MHPC	Program	Program	
$ (44,680)	$ (24,701)	$ 111,577	$ 11,759	$ (32,116)	$ 91,220

Primary Care Physician

The model provided revenue projections and staffing costs associated with adding a primary care physician. Given the assumptions used in the model, revenue did not cover staffing costs. Additional factors, such as a long-term search to find the right staffing fit for MTVHS also played a significant role in the decision not to pursue this new service line. The model relied on assumptions from the medical staff that a full-time provider with sufficient support staff could average seven patient visits a day. Based on prior negotiations, MTVHS estimated that a new physician could be contracted for four days a week, with a half day each week spent on administrative tasks. This work schedule, along with six weeks of vacation annual, amounts to 0.8 FTE. Assuming an average compensation of $160 per patient visit, a single physician working at 0.8 FTE brings in $180,320 in revenue and would serve the primary care needs of 282 individuals in the community with an average of four visits per patient per year.

Figure 6: Primary Care Revenue

Number of days per week serving patients	3.5
Average number of patients per day	7
Average weeks per year	46
Annual patient visits	1,127
Average annual visits per patient	4
Total unique patients served	282
Estimated revenue per visit	$160
Total anticipated revenue	$ 180,320

The Alaska Hospital and Healthcare Association salary survey, reports family medicine physicians earn approximately $180,000 per year. However, this salary survey does not fully capture private practice salaries. To account for this difference, MTVHS estimated that the $180,000 annual salary would be fair compensation for the 0.8 FTE instead of a full 1.0 FTE. Further assuming a 25% benefit rate, total expenses for the single position are $225,000, leaving the program running at a $44,680 deficit.

Figure 7: Model excerpts for Primary Physical Health

0.8 FTE Primary Physician	Assumptions	Rate	Totals
Wages*	$ 225,000	0.8 FTE	$ 180,000
Tax and Benefit rate		25%	$ 45,000
Total Compensation			**$ 225,000**

Medication Management

Noting the rate difference between independent ANP and MHPC billing models, the financial model includes the opportunity to compare rates between the two. All other assumptions are the same between the two revenue calculations. Unlike with the primary care physician, the medication management model assumes a full 1.0 FTE, which includes five days a week seeing patients for six hours a day and the remining two hours for administration and transition. In conversation with the ANPs on staff, MTVHS approximated that such a schedule and credentials would warrant a $135,000 annual salary, with an additional 25% tax and benefit rate added, for a total of $168,750 per year.

Figure 8 Model Excerpts for Medication Management

Psych ANP	Base	FTE	Expense
Wages*	$ 135,000	1 FTE	$ 135,000
Tax and Benefit rate	25%		$ 33,750
Total Compensation			**$ 168,750**

	ANP	MHPC
Total Billable Revenue	**$ 144,049**	**$ 280,327**
Net Revenue	**$ (24,701)**	**$ 111,577**

On such a schedule, an ANP has 1,380 hours available to see patients annually. Time in the model is divided between two services: psychiatric assessments and pharmacological management. Patients begin services with a 90-minute assessment and then return monthly for a 30-minute service to ensure medications are efficient and side effects are managed. The ANP's time is assumed to be split between the services so that 25% of their time is spent conducting assessments and 75% is providing pharmacological management. Based on the payor mix described above and controlling for a 20% missed appointment rate and a five percent non-payment rate, a single ANP could secure $111,577 net

under the MHPC rate but would require an additional $24,701 in funding if billing as an independent provider.

Behavioral Health Crisis

Figure 9: Program Capacity, Crisis

Program Overview	BH Crisis
# FTEs	0.5 FTE
Number of treatment days per year	260
Daily consult + brief intervention capacity	4 hours
Annual consult + brief intervention capacity	1,040 hours
% of hours spent on consults	25%
# of hours spent on consults	260
% of hours spent on brief intervention	75%
# of hours spent on brief intervention	780 hours
Average length of consult	0.25 hour(s) per episode
Average length of brief intervention visit with SBIRT	0.50 hour(s) per episode
Average length of brief intervention visit with crisis intervention	0.75 hour(s) per episode

While behavioral health crisis services will need to be incorporated into the larger MTVHS staffing and program structure, this model analyzes these services as a discrete program with its own staffing costs separate from other services. The model assumes a 0.5 FTE behavioral health clinician in addition to the two FTEs in the outpatient program. The 0.5 FTE clinician is assumed to have four hours of capacity per day for a total of 1,040 hours available for client services per year.

Available hours are then divided into 25% of time providing nonbillable consultations and 75% providing billable brief interventions. Because consultations are not billable, vacancy rate and length of service do not affect that portion of the model. The model shows 260 annual hours when the crisis clinician is available if the physical health staff seek assistance. The other 75% of the crisis clinician's time is divided between two billable services: SBIRT (75%) and crisis intervention (25%) for a total of 780 possible hours. Crisis intervention includes both crisis treatment planning and follow-up psychotherapy services delivered under the crisis plan. The model for the crisis program assumes a high vacancy rate of 50% for available consulting and brief intervention slots, reducing the number of consult hours provided to 130 and the number of brief intervention hours provided to 390 per year.

Figure 10: Staff Expense, Billable and Net Revenue, Crisis

Direct Service Staff Total	$ 61,000
Total Billable Revenue	**$ 28,984**
Net Revenue	**$ (32,116)**

Assuming the 50% vacancy rate for drop-in appointments, billable revenue for a crisis clinician does not cover staffing costs. This model does not estimate the unique number of individuals served with brief interventions or consultations and therefore makes no assumptions about the impact this service would have on community need.

Behavioral Heath Outpatient

MTVHS has two master's level clinicians who anticipate a full caseload of between 20 and 25 clients. Assuming that the average length of treatment is 12 weeks, a total of 199 unique clients will be served each year. Of those 199 clients, all will require an assessment, with the vast majority receiving a mental health assessment and the remaining two percent receiving an integrated behavioral health assessment that includes both mental health and substance use. All clients served will receive individual psychotherapy, with 10% also receiving family psychotherapy.

Figure 11: Outpatient Behavioral Health by Services

Proportion of Clients Receiving Service	BH Outpatient	Hours
Mental Health Assessment (State Plan)	98%	1.50 hour(s) per episode
Integrated Behavioral Health Assessment (State Plan)	2%	2.25 hour(s) per episode
Psychotherapy, Individual (State Plan)	100%	1.00 hour(s) per week
Psychotherapy, Family (State Plan)	10%	1.00 hour(s) per week
Psychotherapy, Group (State Plan)	0%	1.00 hour(s) per week

Based on the estimated length of each service as seen in Figure 9: Outpatient Behavioral Health by Services, and assuming 70% billability, a 20% missed appointment rate, and a five percent rate of non-payment, 23 should be the optimal active caseload for each clinician.

Upon attaining their licensure pay will increase for each behavioral health clinician. Accounting for a 25% tax and benefit rate and an estimated $25,000 for a clinical supervision contract, the total labor expenses for the program are $269,400. These costs are covered by the billable revenue, and leaves $11,759 net revenue.

Figure 12: Billable and Net Revenue, Outpatient

Total Billable Revenue	**$ 281,159**
Net Revenue	**$ 11,759**

Community Partner Meetings

Agnew::Beck worked with MTVHS to identify community partners to prioritize for engagement as part of this planning process. With the exception of the Providence Crisis Stabilization Center and Walk-in Behavioral Health Clinic, which is still in the construction phase, providers shared they have capacity to serve new clients and are eager to develop a referral relationship.

Quyana Clubhouse

Operated by Southcentral Foundation (SCF), the Quyana Clubhouse offers daytime treatment services with recreational activities, an on-site medical clinic, physical education, and a full-service cafeteria. Members participate in treatment planning and have access to all club services.

- Actively seeking new participants. Able to serve SCF customer-owners and any other individual with a serious mental illness, age 18 and over. Eligibility based on assessment to determine if the person can be safe in and benefit from the milieu.
- Treatment-driven programing that seeks to make progress on goals.
- Available amenities and activities include cafeteria, social activities, fitness center, rehabilitative and psychotherapy groups.
- Medication management and psychotherapy services provided in-house, so referring provider cannot retain those services with client.
- Physical health services are also available.
- Undertaking a large expansion in the next three years which will open the program to more people and possibly people with different types of needs.

Cook Inlet Tribal Council

CITC offers a broad range of services, from funding for job training to community cultural activities to residential treatment. Their new Welcome Center serves to connect the people they serve with other available CITC programs. Located an eight-minute bus ride from MTVHS, CITC is well positioned to assist MTVHS patients navigate local resources.

- Welcome Center can connect individuals with a wide suite of services.
- Will send an Uber to MTVHS if needed.
- Provide a wide continuum of services for those with substance use disorders, including outpatient and residential care.
- Willing to discuss providing groups at community locations, such as housing units, if group participants are enrolled.
- Cultural services are defined by the participant's culture.
- Services available to all people residing in Alaska, regardless of background or area of the state.
- Connection to financial resources for training and employment services.
- The Addiction and Recovery department on the third floor takes a "come as you are" approach so those needing support can engage in community as soon as they arrive.

The Alaska Mental Health Consumer Web

Originally founded as an internet café with the vision of sharing stories of recovery, The Web empowers mental health service consumers through a safe and welcoming space without the stipulation that they participate in treatment services. Staff mentors are peers and members are encouraged to explore leadership roles.

- The closest option available locally to the Soteria model, although The Web does not provide housing and their facility is not specifically designated for individuals with SPMI.
- No treatment services. Offers peer-driven mentoring and a safe social space.
- Internet café with couches and non-commercial kitchen for weekly cooking skills group.
- Interested in discussing options for a drop-in medical clinic and open to hosting behavioral health providers in their breakout room.

Providence Crisis Stabilization Center

Currently under construction, the Providence Crisis Stabilization Center will round-out the Crisis Now infrastructure in Anchorage. The center will receive and stabilize those in crisis and offer emergency behavioral health care, including short term residential crisis stabilization and a behavioral health walk-in clinic.

- Needs discharge options for individuals who are stabilized but need immediate MAT and bridge service while waitlisted.
- The new facility will provide crisis care on both a voluntary and involuntary basis.
- Exploring options to build a provider network care coordination.

Alaska 2-1-1

Alaska 2-1-1 connects callers to vital resources in the community and is continually developing new processes to improve how they serve.

- May refer-in callers to MTVHS as a Medicaid-enrolled Urgent care clinic.
- Accepts referrals to assist with Medicaid enrollment and navigating other health insurance options.
- Potential to pilot the closed-loop referral process, which is currently in internal trials.
- Seeking pilot participants for a confidential health information exchange. The provider sends referral information so 2-1-1 can match the patient with appropriate resources, but all identifying data is scrubbed before data is entered into the 2-1-1 system, so Protected Health Information (PHI) remains solely in MTVHS's custody.
- Seeking host locations for case manager weekly hours to help community members enroll in benefits, including Medicaid.

Recommendations

Continue to Strengthen the Core

MTVHS continues to navigate community and organizational changes. In response to community need, they established a strong core program of providing physical health urgent care and built a team of devoted practitioners. These providers and staff recognize additional needs in the patients they serve, but the current work of MTVHS is crucial as is to the health of the Mountain View community. Taking time to build organizational infrastructure will benefit the community by ensuring the sustainability of these vital services. The strategic plan documents significant steps to stabilize the core, including rewriting policy and procedure, building out a quality improvement program, and finalizing processes to bill Medicaid for psychotherapy services. As MTVHS determines the best use for their newly acquired adjacent office unit, Agnew::Beck recommends that any renovation costs be negotiated with the landlord.

Use the Financial Modeling Tool to Support Ongoing Development

The financial modeling tool does not currently integrate overhead costs such as facilities, administrative support and supplies. Agnew::Beck recommends that MTVHS further itemize their operating budget and then apportion those costs to each program modeled to capture indirect costs and to get a more complete picture of additional financial or administrative support programs may need.

Agnew::Beck recommends that MTVHS maintain frequent communication with the Division of Behavioral Health's Medicaid Provider's Assistance Support Services (MPASS). This shared email account operates as a help desk where providers can send questions and receive guidance related to interpretation and implementation of Medicaid regulations. MPASS staff work with a wide range of providers and their guidance, follow-up questions, and reframing of questions can help providers consider new factors and possibilities. All MPASS correspondence should be archived for future reference.

The financial model indicates that a medication management program may significantly benefit MTVHS. These services are already provided through an independent provider billing model but are compensated at a lower rate than if billed via the MHPC model. Shifting existing services to the MHPC model and locating

them within the clinic supports sustainability and access. The model does not account for additional administrative needs for this program, which means additional consideration should be given to potential additional costs and staff time needed to support its operations. The model assumes a full FTE, but MTVHS could consider bringing on a psychiatric ANP to work less than a full FTE schedule.

Expand Community Partnerships

Based on conversations with community partners, MTVHS clearly fills an important niche in the community. Rekindling the connections lost during the pandemic is essential work and Agnew::Beck recommends that MTVHS focus on the referral network and partnerships that emerged through this process. Additional community partners for initial or ongoing connection are identified in the strategic plan.

Day Services

While MTVHS' dream of establishing day services via the Clubhouse model in Anchorage is certainly an option for the future, there are currently multiple options for day activities for MTVHS patients. Agnew::Beck recommends that MTVHS focus on building partnerships with existing day service providers and postpone further exploration of a Clubhouse model while determining criteria for when to revisit this discussion. These criteria may be internal, such as not until MTVHS's next strategic planning period, or external, such as not until community partners fill their current capacity and start to waitlist or decline referrals. Consideration of new community capacity, such as an expansion of Quyana Clubhouse and the possible relocation of The Web should also inform MTVHS decision to pursue this service line.

Linkages to Care

Throughout the planning process, MTVHS highlighted transportation as a barrier to individuals receiving the services they need. Knowing that CITC will provide transportation makes them a particularly helpful partner. Agnew::Beck recommends that all of MTVHS's providers visit the CITC Welcome Center to learn about services provided and ensure that CITC navigators are familiar with MTVHS suite of services.

MTVHS would make an ideal partner for 2-1-1 to pilot their closed-loop referral program once it is ready for external testing. In discussion with 2-1-1, staff expressed a need for community locations for 2-1-1 case managers to operate. Hosting a 2-1-1 case manager once a week in the physical space of MTVHS would ease transportation pressure for patients and further MTVHS's vision of low-barrier access to needed services.

With the pending closure of the Sullivan Arena and the Aviator Hotel, MTVHS will need new sites for their remote clinic services. The Web expressed interest in partnering with MTVHS to provide remote clinic services at their facility.

When the Providence Crisis Stabilization Center opens, a need voiced by center staff was for partners who can accept a discharged individual and maintain MAT services as well as provide bridge behavioral health services while that individual awaits ongoing treatment services. MTVHS's crisis program would be an excellent fit for this and having a regular referral source could help to decrease the anticipated vacancy rate for crisis slots, thereby increasing the financial viability of the program. Providence also expressed interest in collaborating on care and working toward shared information so that individuals experience continuity of care.

MTVHS staff are in an excellent position to engage in conversations with their patients about planning in advance for what interventions they want for themselves when they are unable to express those preferences. For appropriate individuals who would benefit from advanced planning their crisis treatment, MTVHS

should explore psychiatric advanced directives and establish a process for communicating those directives to community partners such as Providence and mobile crisis team.

Primary Care

While MTVHS does not plan to incorporate primary care as part of their service line at this time, former partner Dr. Mendoza launched a new primary care clinic at Umoja CoWorking, just a half mile from MTVHS. Maintaining a referral partnership with Dr. Mendoza will allow both practices to support the Mountain View community with a full range of physical health care services.