Alaska Healthcare TRANSFORMATION PROJECT

Report Version 1 - January 2019

HEALTHY ALASKANS - HEALTHY ECONOMY
EVERYBODY'S BUSINESS
2018 - 2024

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Alaska Healthcare TRANSFORMATION PROJECT AT-A-GLANCE

THE PROBLEM

It's not a secret that Alaska's healthcare costs are high. If you've read the newspaper or listened to legislative debates, you've heard the rising concern over the cost of healthcare. These costs affect private employers and State agencies and impact Alaska's ability to meet other obligations like paying for schools and roads. There is no single solution to this complex problem as we try to navigate our way through to a healthcare system with better outcomes and lower costs.

CURRENT ACTION

Policy makers, state Administrators, healthcare industry leaders, patient advocates and private payers have come together to address the issues through collaborative efforts that pool our collective strategies and will leverage our covered lives for healthcare efficiency and effectiveness.

THE VISION

The vision for Alaska's healthcare system is to improve Alaskans' health while enhancing patient and health professionals' experience of care while lowering the per capita healthcare cost growth rate.

GOALS

The percentage of Alaska residents with a usual source of primary care will increase by 15% within five years.

Reduce overall per capita healthcare cost growth rate to the greater of 2.25% or CPI within five years.

Align all payers, public and private, toward value-based alternative payment models with streamlined administrative requirements within five years.

PROJECT STATUS

A contractor, NORC from the University of Chicago, has been secured to provide stakeholders with information on: Spend and cost drivers of healthcare in Alaska; Meta-Analysis of reports and studies specific to Alaska healthcare over the past 10 years; Review of pilots and demonstrations which have occurred in Alaska; and National scan of innovative healthcare delivery in other states. Reports are due early 2019. Recommendations for Alaska Healthcare Transformation to occur by June 2019.

PREFACE

IT'S NOT A SECRET THAT ALASKA'S HEALTH CARE COSTS ARE HIGH.

If you've read the newspaper or listened to legislative debates, you've heard the rising concern over the cost of health care. These costs affect private employers and State agencies and impact Alaska's ability to meet other obligations like paying for schools and roads. We aren't alone – the growing cost of health care is straining state budgets and raising concerns about the nation's ability to manage its growing deficit. There is no single solution to this complex problem which increases frustration as we try to navigate our way through to a healthcare system with better outcomes and lower costs.

We have dedicated Alaskans who are committed to working together to improve our state's healthcare system. In order to make lasting and sustainable change to the healthcare system there needs to be alignment and collaboration across policy makers, state Administration, health care industry leaders, patient advocates and private payers along with broad stakeholder engagement and communication that takes public perception of the healthcare spend into consideration. We need to maximize collaborative efforts by pooling our collective strategies and leveraging our covered lives for healthcare efficiency and effectiveness.

Healthcare – both in its delivery to patients and as an economic driver, is vital to the Alaska economy. Ultimately, we want to reduce the overall healthcare spend by making healthcare delivery more efficient. We know that just reducing the price of what we are willing to pay does not equate to cost reductions; however, price reductions may equate to access and quality reductions. We want to understand the market pressures that have occurred that have driven down costs and embrace strategies that can be leveraged to ensure these market pressures can happen more quickly.

The Alaska Healthcare Transformation Project will be for the whole population (including Medicaid) and should include all payer sources, all delivery systems and all residents. We understand that change is hard and there will be mutual sacrifice and benefits. Additionally, there will be a transitionary uptick in cost as the system adjusts to the shift in measuring outcomes and changes to payment methodologies.

If determined feasible, an Alaska health care authority may be able to address the price of healthcare by managing what's paid for and for how much. The healthcare blueprint can address cost by managing the way care is delivered and paid for. Together they address quality outcomes and access through efficient and effective use of resources.

HISTORICAL EFFORTS

The Alaska Healthcare Transformation Project will build on previous efforts that have sought to address reforms of the Alaska healthcare system. Over the past ten years, Alaskans have come together under the Health Strategies Planning Council, the Health Care Commission, Medicaid Task Force, and the Medicaid Reform Advisory Group. Most recently, in 2016, our legislature in cooperation with the administration and the health care community, passed an omnibus Medicaid redesign bill. Implementation is actively underway. This bill contained, among other reforms, a feasibility study for the development of a health care authority to potentially pool purchasing and administration of state funded healthcare services, coordinated care demonstration projects and a redesign of the behavioral health system through an 1115 waiver. Additionally, the 2017 legislative session brought forward suggested legislation on balanced billing, elimination of certificate of need and price transparency. Finally, Alaska was awarded a 1332 waiver to address the costs of the high-risk pool. These efforts have focused on the need to address the spiraling healthcare costs in our State. The individuals involved with these previous efforts are to be commended; however, there is concern that without thoughtful consideration and review of the entire healthcare system we will perpetuate the history of reform activities that do not address the core need for a comprehensive, integrated health care plan that can move the needle in lowering health care costs while improving access to quality healthcare.

As the Alaska Healthcare Transformation Project progresses a review of current efforts will occur to determine areas we can build upon to ensure alignment as these efforts move forward. The feasibility of a healthcare authority is of particular interest as the State explores possible coordination and integration of health plan administration, common benefit package design elements and pooling of covered lives to maximize purchasing opportunities.

"There are just no easy answers. There are certainly no answers that are going to allow you not to change. There are no answers that will allow you to protect the status quo."
- Governor John Kitzhaber

PROJECT BACKGROUND

Alaska has a sporadic history of working towards reforming our healthcare system. As a fairly young state, many of our health reform activities have actually focused on growth and building of infrastructure. The growth was responsive to local need but lacked systematic and strategic planning. The result has been healthcare delivery systems and funding structures that lack efficiency and struggle to maximize utilization controls. The unsustainable growth in healthcare costs has necessitated our focus towards better management and coordination of our health care dollars and services.

Alaska did not participate in the state innovation model funding that was made available during the early stages of implementation of the Affordable Care Act. This left us at a significant disadvantage in trying to plan and implement comprehensive reform. However, our reticence may be to our advantage as we look to successes in other states that are further down the reform road than Alaska. We can learn and borrow approaches from the other states that have implemented strategies that have reduced their costs while improving access to quality healthcare.

The Administration, legislature, private entities and providers have been grappling with rising healthcare costs from their own unique perspectives. In Spring, 2017 a small group met in Juneau to see if there was an avenue for us to bring together our collective knowledge and begin work on a comprehensive healthcare plan for Alaska. From the experience of other states, we knew this would require leadership, commitment and money to effectuate the needed change. We agreed to work together and began the process of attempting to secure funds for the project.

Rasmuson Foundation awarded the Project a $25,000 grant to clearly articulate the role of a Project Management Committee with governance structure, decision making and fund disbursement responsibilities; a solid outline or table of contents for the Alaska Healthcare Transformation Project; the public engagement process that would engage stakeholders affected by the plan; and, a budget for the total project.

INITIAL PLAN DEVELOPMENT

Convening group

The planning process was kicked off with a day long convening.The convening group consists of stakeholders from public and private payers of healthcare, providers of healthcare, policymakers and patient advocates. The convening group represents the viewpoints of their respective group, sends information out to others, and is committed to working collaboratively to address health care challenges in Alaska.

The convening group meets at regular intervals to review the work of the project
The day started with opening remarks from Senate President Pete Kelly, Representative Ivy Spohnholz, Governor Walker Chief of Staff, Scott Kendall, and ASHNHA CEO Becky Hultberg followed by a presentation by former Oregon Governor John Kitzhaber. The majority of the day was spent in small group and report out structure.

The first day was attended by 56 people. The goal for Day 1 was to address the following questions:

- What does a system of health for Alaska look like?
- What are the principles by which we get to that destination?
- What are the building blocks that need to be included in our healthcare blueprint?

Process

Participants were assigned to smaller groups and given a series of questions to debate and discuss within their groups. The groups were arranged to provide a mix of interest and representation with groups no larger than eight members.

By embracing the following concepts, we completed phase one:

- Engage the usual and non-usual participants in dialog
- Expect "heat"
- Seek points of alignment
- Articulate outcome and principles to address with the challenge
- Establish steps to achieve outcome (building blocks)
- Prioritize first step and implement
- Learn from failure or success
- Build momentum through next steps
- Ongoing evaluation, correction
- Work together

At the end of the first day the larger group indicated there was value in the process, and that they would support having a second meeting.

The following day a smaller group met to recap the event and identify some direction/common themes. These are described in the following sections.

PROJECT VISION

The vision for Alaska's healthcare system is to improve Alaskan's health while also enhancing patient and health professional's experience of care, and lowering the per capita healthcare growth rate.

> "Every time something gets more complicated, it becomes more challenging to resolve. But it can be resolved. It can be resolved if we are courageous, if we make sure that we know that we want to put the end goal of having better health care quality for all Alaskans at lower health care costs and if we be humble about that."
>
> - Rep. Ivy Spohnholz

GUIDING PRINCIPLES

- Focus on improving individual and population health outcomes (defined holistically including mental, behavioral, oral, vision and social health).
- Health coverage for all with common basic benefits. There is shared responsibility in reforming and paying for coverage, with everyone – individuals, business, insurers and governments – playing a role.
- Focus on whole person/integrated systems of care
- Use proven healthcare delivery practices supported by appropriate payment mechanisms.
- Seeking recognition and ways to incorporate social determinants of health in patients' care plans.

GOALS

Participants were assigned to smaller groups and given a series of questions to debate and discuss within their groups. The groups were arranged to provide a mix of interest and representation with groups no larger than eight members.

Goal #1
Healthy Alaskans
The Percentage of Alaskan residents with a usual source of primary care[1] will increase by 15% within five years

Goal #2
Healthy Economy
Reduce overall per capita healthcare growth rate to the greater of 2.25% or CIP within five years

Goal #3
Everybody's Business
Align all payers, public and private, toward value-based alterative payment models with streamlined administrative requirements within five years

[1] Primary Care Providers would include licensed primary care physicians, advanced nurse practitioners and physician assistant's active in the practice of family medicine, primary care internal medicine, or pediatric medicine. A behavioral health provider may serve as the Primary Care Provider if the enrollee's primary diagnosis is a behavioral health condition.

STRATEGY DEVELOPMENT TEAMS

Overview

Following the development of the vision, guiding principles and goals for the project, strategy development teams were formed to develop actionable strategies to move towards objectives. Strategy development teams met in Spring, 2018. The strategy development teams were divided into the following topic areas:

- increasing primary care utilization;
- coordinate patient care;
- changing the way healthcare is paid for in Alaska;
- increasing data analytics capacity; and,
- addressing social determinants of health.

Each team consisted of representation from policymakers, providers, payers and patient advocates and were charged with defining requests for further investigation towards evidence-based recommendations in their respective area. Requests included actuarial and other economic analyses, system design research, pilot project design, site visits to other states and other consulting services. The requests from the strategy development teams can be categorized as:

- Understanding the drivers of the spending and cost of healthcare in Alaska.
- Learning from what's been done already in Alaska via "experiments" or meta-analysis of reports/studies.
- Learning from other's models, structures, etc. in other states and how to apply in Alaska.

This phase of the project funded by the AK Mental Health Trust, AK Children's Trust and the State of Alaska operated through June 30, 2018.

Communication Plan

The comprehensive nature of the Alaska Healthcare Transformation project assumes that all Alaskans are stakeholders and should be informed about the impacts of any proposed changes to the healthcare delivery system. Some stakeholders (e.g., providers, insurers, employers) may be more directly affected by reform efforts. Some stakeholders are important because of the key roles they play in helping to educate, influence, and advocate for healthcare system users. While others will manage policy levers through regulation addition or elimination. Because of the various roles, communication will need to employ multiple strategies to ensure stakeholder views are gathered and considered throughout the plan development process.

COORDINATED CARE

Summary of Coorindated Care

System wide approach to patient centered whole person care

COMPONENTS OF COORDINATED CARE SYSTEM

Structural

- Regional or community approach based on community need – system design does not have to be homogenous. Appropriate care needs to be available as close to home as possible. Build support and capacity for local care.
- Collaborative relationships among health and social service providers. The system offers incentives to collaborate.
- Everyone is using an intezroperable information technology platform. Real time clinical information exchange across all health care sectors (i.e everyone on EDIE / PreManage).
- Improved tele-medicine and tele-consultation across all health care sectors.
- Availability of video-conferencing with more providers, not just Indian Health Service patients. Technology needs to meet the provider where they are at and provide the information they need at the time.
- Everyone has the opportunity to engage with interoperable information technology resources that provides access to clinically relevant information to improve patient outcomes
- Fragmentation in healthcare is the enemy of Quality. Dealing with the fragmentation in Alaska's healthcare system is vital to effective care coordination.
- Maximize use of health options by more providers and provide a forum for exploring innovative options.
- Statewide conference to share best practices and explore innovation strategies showing success in Alaska.

Quality care

- Innovation and health leadership conference to share best practices throughout the state with policy discussions and educational offerings for payers, providers, social assistance and no-traditional partners such as troopers or police.
- Equitable care for all Alaskans to accelerate the elimination of health disparities throughout the state.
- Alaska has better healthcare than the lower 48.

Payment

- Payment models that support and incentivize quality.
- Fee for service is replaced with incentive payments for more practical, quality and wellness care (fee for service with pay for performance; risk-adjusted global payments to networks of providers; risk-adjusted, bundled, episode of care payments).
- Add job satisfaction and value to the community in the payment structure.
- Maximize Alaska healthcare system as an asset to local communities and minimize its burden on the overall economy to create a high value system.

Relationships

- Foster environments that incentivize healthy behaviors, maximize prevention strategies and shifts to a system of care that focuses on patient engagement and improved care.
- Prioritize time for patient/provider relationships to develop and grow.
- Improve provider relations between traditional and non-traditional providers via education, interaction, interoperability of health care systems and feedback on health care and health outcomes.
- Patients with complex diseases require a large amount of healthcare resources and will likely have the largest individual benefit from effectively coordinated care. However, patients with common diseases still benefit from coordinated care and, though their individual benefit is likely smaller, the benefit to population health may be larger. Both deserve a healthcare system that offers them coordination of care.
- Culture shift(s) – "The enemy is poor health":
  - High-risk, high utilizers are high cost but only 5% of the population, coordinated care needs to focus on all patients.
  - Patient engagement includes being prepared, knowing medications, being self-advocates.
  - Practitioners "meet" the patient where they are (patient portal, integrated patient communications platform, organizational culture of engagement – policies and procedures supporting patient engagement).
  - Culture is locally driven.
  - View that Alaska healthcare delivery is less than – experts are only in the lower 48.
  - Patient experience and provider experience is not mutually exclusive.

> "But what I found is that people working in Medicaid and health care in the state have an incredible work ethic. They're professional people. They care a great deal. But they're trying to manage a system that's flawed, and you're always going to be frustrated if that's the case."
>
> - Senator Pete Kelly

DATA ANALYTICS

Summary of Data Analytics

Data analytic system will support and be accessible to providers, hospitals, insurers, government payers, policymakers and consumers to decrease health care cost, improve quality, ensure access and improve the patient experience.

COMPONENTS OF DATA ANALYTICS SYSTEM

Goal

- Submission of data from payers is least burdensome with value-added reporting/analysis to stakeholders and the public.
- Create shared services reducing the reporting burden and adding benefit back to the stakeholder community

Functionality

- The data analytics system would provide for claims and clinical integration including public health registry with linkages to other registries.
- Data collection is centralized to a data warehouse for extraction with analytics for end users. Federated model with interoperability.
- Collect meaningful data elements that serves needs of stakeholders.
- Streamline data collection through HIE into data warehouse to decrease administrative burden to non-government and governmental agencies.
- Ideal is to get the health information exchange data into a warehouse for public health to use with accurate information to drive policy decisions.
- Incentivize all stakeholders to participate. Includes tribal health, DOD/VA, self-insured.

Governance

- Solicit stakeholder engagement from the beginning to define authority, control and shared decision-making. Intentional discussion.
- Data elements and rules are well defined.
- Government analytic capacity is centralized in single agency.
- Reduced lag time between data reporting to the state and consequently back out to stakeholders.
- Increased data sharing and leverage to drive decision-making.
- Sharing data is important – translating data into action is critical. Ensure data are used to improve system of care.

> "There's a lot of value in coming together and having these conversations together so that we can identify, what are the things, what are the steps we can take today to help put us on a more sustainable trajectory in the future."
>
> - Becky Hultberg
> CEO, ASHNHA

Culture Shift

- Importance of data collection needs to be believable and convincing to the public and stakeholders in to get full participation and commitment.
- Continuous collaboration.
- Iterative process – not one and done.
- Incorporate flexibility and resilience to allow for technological, clinical, payment, etc. change
- Purposeful, incremental and transparent approach.

PAYMENT REFORM

Summary of Payment Reform

Diverse provider network that includes physical, behavioral and supportive services, contracting with multiple payers for a shared savings risk model to serve a large group of members with a goal of improved value for payers, providers and members.

COMPONENTS OF PAYMENT REFORM

Structural
- Payers are aligned.
  - All payer rate setting schedule through a regulatory commission structure.
  - Prior authorizations are aligned.
  - Same requirement for prior authorizations, same basic coverage of benefits allowing providers to add additional benefits, payment alignment.
- Collaborative, interoperable, virtual clinically integrated network.
- Payers negotiate with network not individual practitioners.
  - Shared risk/shared savings models.
- Cost of care transparency occurs through multiple sources not just one.
- Network negotiates outcomes-oriented payments or bonuses to participating providers to encourage collaborative, efficient use of care and incentivize using lower levels of care and addressing social determinants of health to improve health outcomes.
- Financial relationship should be between the patient and the payer. Payer collects the deductible from the patient, not the provider.

Patient Engagement
- Individuals are able to "buy-up" for services beyond a basic benefit package.
  - Plans are portable.
  - Health savings account structure.
- Insurance is for the costs you can't cover yourself, typically catastrophic events.
- Consumers are engaged in healthcare spending and own health – inappropriate use of resources has financial consequence.
- Patients are encouraged to use preventative care and other means to improve health and prevent higher cost of care.

Tools
- Standardized list of procedures that are covered to create common dialect – streamlining of procedures, quality metrics.
  - Procedures and services are ranked by evidence base and cost-benefit to patient and system and this ranking is used to encourage utilization of higher value services over lower value services.
- All payer's claims database.
- Interoperable electronic health records and data analytics capacity.
- Strong negotiation for purchasing pharmaceuticals and promotion of generics and lower-cost alternatives.

PRIMARY CARE

Summary of Primary Care
A primary care system is made up of a team of health care professionals that together offer comprehensive whole patient care. Best practices show that ideally primary care should look like a community of engaged practitioners actively involved in the well-being of their patients. The patient also plays a role in the management of their care.

COMPONENTS OF A PRIMARY CARE SYSTEM

Structural
- Interoperable, multi-specialty, virtually integrated system with healthcare providers and social assistance.
- Real-time measurement with standards and compliance for clinical decision making.
- Quality metrics/forms/rate structure standardized across payers for preventative care.
- Population management software needs to be real time.
- Shared services model to support independent and small practices.
  - Private sector development.
  - Includes co-op models being utilized in the lower 48.
- Practicing at the top of license includes telemedicine.

Patient Engagement
- Consumerism related to patient responsibility of care.
  - Access to individual health records.

Payment
- Attribution tied to network versus individual practices.
  - Models could include: shared risk/savings.
- Flexible rates of reimbursement to allow for:
  - Reimbursement of communication with care team.
  - Life span changes.
- Establish a base price for services. Change the payment scheme to incentivize quality with reduction when quality metrics are not met.
- Establish a payment structure based on the cost of the service/treatment versus who provides it.
- Payers stop negotiating different costs for the same procedure.

SOCIAL DETERMINANTS OF HEALTH

Summary of Social Determinants of Health
Infrastructure support for social determinants of health: identification and coordination of resources

COMPONENTS OF SOCIAL DETERMINANTS OF HEALTH SYSTEM

Structural
- Back office functions are coordinated regardless of payer.
- Seamless entry into the system, no wrong door.
- Once need is identified, resources as appropriate are available to connect to ????
- The reimbursement system should be structured to direct resources where needed - focus on social assistance, training and technical assistance – with incentives and payment models which are sustainable and permanent and in support of social determinants of health.

Tools
- Screening for social determinants of health becomes as standard as height, weight and blood pressure.
- Community based organizations are included in the formal network of support.
- Align payment and administrative models.
- Robust technology systems with outcomes and looping back to practitioners and members.

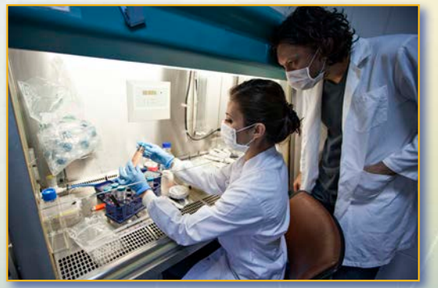
Patient Experience
- Connections can be made from anywhere (primary care, specialty, courts, police, etc).
- Address areas with greater concentration of inequities (homelessness, housing, food, interpersonal violence, disparate populations, education).

Culture Shift
- The philosophy of the healthcare system related to social determinants of health is the system and supports have to be connected.
- Acceptance that social determinants of health affects overall health.
- Economic justification or case for why addressing SDOH is important.
- Teach about social determinants of health in medical schools.
- Health literacy at all levels (K-12 and beyond).
- Peer supports.

RESEARCH

Overview
The backbone of comprehensive planning is a community-collaborative approach involving partnerships within and among State agencies and other public, private, and community organizations, to break down traditional barriers and organizational silos. The partners develop a global plan for the state, and they share responsibility and accountability for it. In this environment, stakeholders can work together on all fronts to combat the health problem through integrated and coordinated efforts with shared priorities.

Simply limiting payments is not sustainable over the long term without delivery system reforms that promote efficiency. Controlling system-wide costs will require more ambitious efforts on the part of health systems and more aggressive policy changes than have been enacted to date. The plan development phase will require the continued involvement of the Project Management Committee , the Convening Group and Strategy Development Teams. The services of a fiscal sponsor and project coordinator have been secured. The lion's share of the plan development will be completed through the coordination and development of work plans by the strategy development teams.



Scopes of Work
Scopes of work were developed with a contractor, NORC, secured to provide stakeholders with information on:
- Spend and cost drivers of healthcare in Alaska; Meta-Analysis of reports and studies specific to Alaska healthcare over the past 10 years; Review of pilots and demonstrations which have occurred in Alaska, and;
- National scan of innovative healthcare delivery in other states. Reports are due early 2019. Recommendations for Alaska Healthcare Transformation activities to occur by June, 2019.

GOVERNANCE

Project Management Committee
The governance role of the Project Management Committee is to provide overall direction, guidance and support to the project, and to monitor the project to ensure successful delivery of expected outputs and outcomes within scope and budget. The governance model is a consensus model whereby each member has an equal vote, equal responsibility and equal liability. There is no hierarchy and no one individual has power over another.

The Project Management Committee will adjourn upon successful completion of the finalized written Alaska Comprehensive Healthcare Plan.
- Establish overall project requirements and priorities, has ultimate authority and responsibility for the project.
- Strategic planning and executive decision[2] point resolution.
- Articulate a project vision (What it is and what it isn't).
- Identifies, justifies and plans for the project's funding through its completion ensuring the project is within the budget for each of its budgeted years.
- Allocates resources to support project implementation.
- Communications external to the project and to the key stakeholders that have a vested interest in the project.
- Identify other stakeholder groups and make sure they are part of communication
- Ensure project alignment with overall objectives.
- Approves changes to scope, budget, objective and plan.
- Signing off the project deliverables at the relevant milestones.
- Meet monthly to review progress and ensure continued alignment.
- Approve final plan document.
- Provide recommendations for plan implementation and ongoing healthcare policy decision-making structure.

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[2] Step 1: Identify the decision - clearly define the nature of the decision to be made
Step 2: Gather relevant information - what information is needed, the best sources of information, and how to get it.
Step 3: Identify the alternatives - identify several possible paths of action, or alternatives.
Step 4: Weigh the evidence – evaluate and prioritize
Step 5: Choose among alternatives - select the alternative that seems to be the best one
Step 6: Take action - take some positive action by beginning to implement the chosen alternative
Step 7: Review the decision & its consequences - consider the results and evaluate whether or not it has resolved the need

Project Coordinator

The project coordinator will act as liaison between the fiscal agency and the project management committee, manages the workflow of the strategy development teams, ensures timelines and deliverables are met while meeting quality standards, and ensures the scope of the project stays within agreed upon boundaries.

- Plan, organize, coordinate and control the project effort.
- Communicate with and direct team leaders for achieving the defined outcomes aligned with the project objectives.
- Ensure on-time delivery of specific deliverables.
- Set up and manage tasks and activities within the plan framework.
- Stakeholder management - Stakeholders are the people who have a vested interest in the outcome of the project.
- Monitoring the project progress, including sub-projects.

Fiscal Sponsor

- Financial management of Project funds anticipated to be in the range of $1,000,000 from at least three separate funding sources:
  - Fund disbursal
  - Expense tracking
  - Required reporting
- Management of contracts let for services to include but not be limited to: project coordination, research, actuarial studies. Contract scope and available funding levels will be approved by the Project Management Committee.
  - Procurement
  - Contract term development
- Personnel management of project staff as the employer of record.
- Administrative support.

"Ultimately we have to keep working together. And what builds movements is clarity on destination and the principles by which to get there."

- Dennis McMillian
Consultant

ACKNOWLEDGEMENTS

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Members of AK Health Reform include:
- Alaska State Hospital and Nursing Home Association
- Alaska Primary Care Association
- Alaska Behavioral Health Association
- Mat-Su Health Foundation
- Rasmuson Foundation
- AARP
- Alaska Mental Health Trust Authority

The members of the Project Management Committee who provided guidance, input and feedback into the planning structure include:
- Senator Natasha von Imhof
- Representative Ivy Spohnholz
- Elizabeth Ripley, Mat-Su Health Foundation
- Kalani Parnell, Alaska Native Tribal Health Consortium
- Becky Hultberg, AK State Hospital and Nursing Home Association
- Nancy Merriman, AK Primary Care Association
- Pat Pitney, OMB Director, State of Alaska

Participating stakeholders across payers, providers, policymakers and patient advocate domains. Valued contributors to the discussion included:

Ian Stark, Public Educators Health Trust
Mike Powers, Tanana Valley Clinic
Becky Hultberg, ASHNHA
Ivy Spohnholz, Representative
Nicole Gorle, Governor's Office
Steve Williams, AMHTA
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Glenn Bafia, NEA Alaska
Natasha Pineda, DOA
David Wilson, Senator
Andrew Cutting, AK Children's Trust
Thea Bemben, Agnew:Beck
Jeannie Monk, ASHNHA
Thomas Showalter, Wilson Albers & Co
Kevin Munson, Mat-Su Health Services
Moira Gallagher, AEDC
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Ben Helsel, AETNA
Jared Kosin, Mat-Su Regional Medical Center
Jake Lauten, SOA
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Verne Boerner, ANHB
Ken Osterkamp, AARP
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Heidi Lengdorfer, DHSS
Fred Brown, HCCMA
Cathy Giessel, Senate
Alan Gross, MD, Practitioner
Ward Hinger, Imaging Associates
Gloria Jueneman, AK Heart Institute
Nirav Dalal, IMB Watson
Kevin Moore, United Health Group
Melisa Kemberling, MSHF
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Sherrie Hinshaw, VOA
Angela Rampoin, DCCED
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