Alaska Healthcare Transformation Project

Alaska Historical Scan

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Executive Summary

Health reform has been on the agenda of Alaska residents for over a decade, driven by high health care costs and concerns about quality and access to care, as well as sustainability of the state's delivery system overall. This mirrors events nationally, where passage of the Patient Protection and Affordable Care Act in 2010 ushered in a generation of payment and delivery system reform experiments, in addition to efforts to expand health insurance coverage through Medicaid and the marketplaces.

This report adds to the picture of reform and its prospects in Alaska, presenting a summary of selected health reforms over the past decade (2008-2018). It is one of four reports being prepared by NORC and its partners at the University of Alaska Anchorage (UAA) —the Institute for Social and Economic Research (ISER) and the Institute for Circumpolar Health Studies (ICHS)—under contract with the Alaska Healthcare Transformation Project. Together, these four reports are designed to take stock of past reform efforts in the state, learn from the experiences of other states, and identify next steps to craft a comprehensive strategy or roadmap for state-level reform. In this report, we consider a common set of five key topics of interest—primary care utilization, coordinated care, data analytics, payment reform, and the social determinants of health—and assess geographic distribution of reform across seven Alaska regions.

Much health reform is rooted in the federally-financed infrastructure built in the years during and after World War II. Health policy during midcentury in Alaska, around the time of statehood (1959), emphasized addressing the spread of communicable disease, training of providers to begin to meet the needs of residents—many of whom lived in areas with little, if any, access to quality health care—and attention to mitigating the impact of several non-medical social determinants of health (namely, substandard housing, lack of access to potable water and sewerage, and food insecurity). Current-day policies, programs, and health care facilities also bear the imprint of Alaska's remote geography, climate and weather, and patterns of settlement. These characteristics, unique among the states, influence ongoing efforts to mitigate the challenges posed by the need to bring health care to patients and families or vice versa (e.g., medical transportation) and to collect and share information across great distances, whether by radio or more recently, as enabled by broadband internet service. The layers of Alaska's complex payer environment (e.g., federal, state, and commercial) and decentralized delivery systems (e.g., tribal, private sector, Department of Defense, and Veterans Administration) developed incrementally over decades in the state, and alongside these systems, groups of stakeholders and constituencies whose perspectives are critical to include and address in reform deliberations.

While the tension between provider autonomy and more centralized oversight—whether governmental or organizational more generally—is an important theme in Alaska's health history, another key theme is that of the value placed on cross-sector collaboration in strategic planning, particularly those that bring AI/AN and state partners jointly to the table. Two examples stand out from Alaska's past: that of the health systems agency planning and related certificate of need process that have guided decision-making about infrastructure investments starting in the 1970s, and the Healthy Alaskans 2020 consensus-driven planning process to set population health goals. Both examples illustrate a middle path between autonomy and oversight that has demonstrated success for Alaskans.

Selected Health Reforms, 2008 to 2018

Eleven recent health reforms identified by the PMC offer insights into next steps for Alaska. Considered as a group, they underscore the leadership role played by the Alaska Native Tribal Health Consortium (ANTHC) in reform around primary care, the leverage toward reform created by federal dollars and through state administration of the Medicaid program, and the clustering of reforms in more urban parts of the state, specifically Anchorage, the Mat-Su Valley, and southeastern Alaska.

Exhibit ES.1: Selected Health Reforms in Alaska, 2008 to 2018

Name	Status	Topic
Statewide Scope		
Complex Behavior Collaborative	Ongoing	Primary Care/ Coordinated Care
Medicaid Coordinated Care Initiative	Ongoing	Primary Care/ Coordinated Care
PCMH Initiative, including pilot	Ongoing	Primary Care/ Coordinated Care
Transforming Clinical Practice Initiative	Ongoing	Primary Care/ Coordinated Care, Data Analytics
Reforms Based in Anchorage and/or Matanuska-Susitna Valley		
Nuka System of Care	Ongoing	Primary Care/ Coordinated Care
FQHC Advanced Primary Care Practice Demonstration	Complete	Primary Care/ Coordinated Care
Strong Start for Mothers and Newborns Initiative	Complete	Primary Care/ Coordinated Care
Bundled Payments for Care Improvement: Models 2 and 3	Ongoing	Payment Reform
Other Regional and/or Local Reforms		
Prince of Wales Health Network	Ongoing	Primary Care/ Coordinated Care, Social Determinants of Health
Kodiak Area Native Association (KANA) Electronic Clinical Reminders	Complete	Data Analytics
Health Care Innovation Award	Complete	Primary Care/ Coordinated Care

Regional Distribution of Reforms. Four of the reforms are statewide in scope—three related to the Medicaid program and one (the Transforming Clinical Practice Initiative) related to capacity building in the areas of data analytics and the healthcare workforce. Another four reform efforts are located in or near the population centers of Anchorage and Matanuska-Susitna Borough, including Southcentral Foundation's Nuka System of Care and three demonstrations funded by the Centers for Medicare and Medicaid Services (CMS). In addition, there are two reforms based in Southeastern Alaska (Prince of

Wales Health Network and PeaceHealth Ketchikan Health Care Innovation Award). None of the highlighted reforms are located in the Northern or Interior regions of the state.

Leadership of Reforms. Most reforms are led either by tribal health organizations or by providers under agreement with state agencies (most often, the Alaska Department of Health and Social Services) (AKDHSS).

Entities Funding Reforms. Federal dollars and programs support most of the reforms selected. Nearly half (five of the eleven) are funded by CMS.

Topics of Reform. Nine of the eleven reforms highlighted here are focused on primary care and coordinated care, with payment reform and data analytics each represented by one reform initiative, respectively.

Populations Served by Reforms. We know more about the identity of residents to be served by reforms and less about the actual number targeted or actually engaged, as patients, family members or caregivers, or as members of the general public intended for outreach or health education as part of reform. The highlighted reforms serve Medicaid enrollees, Medicare beneficiaries, AI/AN residents served through tribal health organizations, and groups defined geographically, for example, those served by specific clinics or empaneled to receive care through a particular reform model.

Outcomes. We lack validation for much of what is documented about these reforms; the NORC team identified program evaluations or peer-reviewed publications specific to Alaska for six of the eleven initiatives. Southcentral Foundation's Nuka system offers the most evidence to date of effectiveness, with findings of more appropriate care (in the case of managing diabetes), greater customer-owner satisfaction, reduced inappropriate ED utilization and hospital readmissions, and cost savings. Evidence about other reforms is limited but promising: positive findings are seen for the Complex Behavior Initiative and the Coordinated Care Initiative's emergency room diversion program. The Kodiak Area Native Association's use of electronic clinical reminders was associated with improved screening rates for preventive care and PeaceHealth Ketchikan's care coordination pilot with improved care process measures for diabetes. National evaluation findings that included data from Alaska sites identify improved in utilization, process of care, and cost outcomes (FQHC Advanced Primary Care Practice Demonstrations), improved quality of care and cost savings (Bundled Payments for Care Improvement Models 2 and 3), and improved outcomes for pregnant women and their infants (Strong Start for Mothers and Newborns). However, the generalizability of these findings from national to local sites is unclear.

Gaps in Reform. While many reforms have been launched in the past decade, and the pace of reform has accelerated with enactment of SB74, there are many regions, populations, and outcomes not encompassed by this list of eleven reforms. Reforms cluster in the more densely populated, southern end of the state. Initiatives led by or funded by the Department of Defense or the Veterans' Administration are not included. For the most part, these reforms do not address dental and vision care, access to durable medical equipment, the broader field of long-term services and support, or institutional, residential care. Reforms are limited in terms of the payment models tested to date (bundles, capitated monthly payments) and the delivery system changes (PCMH and a small number of risk-sharing models).

Short-term and long-term policy change

- Leverage the historical experience of Alaskan public officials and stakeholders with multi-sector planning coalitions that bring all parties to the table—both Native and non-Native, state and private sector, federal and state, providers and payers—following the examples of health systems planning and the certificate of need process that began in the 1970s and more recently, with the Healthy Alaskans 2020 planning process. Such sustained engagement to define the scope of reform, for example, to place social determinants of health more squarely inside the focus of reform, is likely to be more robust and gain greater acceptance and engagement.

- Continue to use the AKHCC's comprehensive set of recommendations around primary care reform as a launching point but acknowledge that PCMH, as a delivery system reform that may be yoked to diverse payment schemes, may not necessarily yield desired, substantial cost savings over the long term. For example, greater access to specialists and hospitals enabled by coordinated care may contribute to higher health care costs. While the Nuka model is an internationally acknowledged touchstone for primary care reform, there are multiple challenges to replication or scaling outside of the tribal system. The capability of ANTHC as a delivery system to braid or align multiple revenue sources around coordinated care, and the substantial investment in cultural change within the health care organization, toward an emphasis on relationships between customer-owners and clinicians, may not be readily realized outside of tribal health organizations.

- Continue to invest in strategies to bridge the great distances that separate many of the state's residents from each other and from essential health services and programs that address non-medical SDOH. Published evaluations provide evidence of the efficacy of reforms in telemedicine (including broadband access in remote parts of the state), workforce development that taps Alaska residents for training and employment (e.g., the aide programs developed by the tribal system), and payment reforms that support coordination across the continuum of care (e.g., the specialty co-management model of Project ECHO) and across settings (e.g., the Extended Frontier Clinic model that stabilizes residents after hospital discharge and before returning to community living).

Programmatic changes

- Identify nationally-validated performance measures that are meaningful to health reform in the state and support their addition to current state data systems (e.g., claims submitted for Medicaid reimbursement).

- Invest in evaluation of health reforms, and in local capacity to design and conduct evaluations, to give a rigorous evidence base that can guide reform tailored to the needs, experiences, and expectations of Alaska residents.

System redesign changes

- Acknowledge the defining characteristics of health services delivery in the state over time, deeply oriented towards fee-for-service reimbursement and shaped by the dynamic between federal and

state-level organization and revenues and that of local autonomy. Consider reforms that directly address and, ideally, take advantage of these characteristics of existing delivery systems.

- Continue to re-align Medicaid purchasing with federal reform opportunities through the waiver programs, for example, system redesign opportunities under section 1115, reinsurance that was successful in shoring up the ACA marketplace under section 1332, and greater investment in rebalancing long-term services and supports from institutional to home- and community-based services under section 1915 waivers.

- Support greater coordination across health services delivery and social services as a promising approach to address the contributions of SDOH to adverse health outcomes. For example, the Housing First evaluation finds that an integrated approach to permanent supportive housing is associated with improved health and wellbeing for at-risk, formerly homeless residents. Cost savings were not seen with this model, which may reflect the characteristics of this population and their lack of access to quality health care prior to moving into Housing First units.

The historical sketch of Alaska's health reform landscape offers themes to consider as the Alaska Healthcare Transformation Project continues to do its work. These themes or preliminary ideas are suggestions for further analysis, to inform development of the NORC team's third and fourth reports. Together, all four NORC team reports will contribute to creation of a roadmap for health reform, both in the short-term (under 12 months' time) and in the long-term (the next five to ten years).

Chapter One: Introduction

Health reform has been on the agenda of Alaska residents for over a decade, driven by high health care costs and concerns about quality and access to care, as well as sustainability of the state's delivery system overall. This mirrors events nationally, where passage of the Patient Protection and Affordable Care Act in 2010 ushered in a generation of payment and delivery system reform experiments, in addition to efforts to expand health insurance coverage through Medicaid and the marketplaces.

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The Alaska Health Care Commission. In 2009, the Alaska Health Care Commission (AKHCC) began its work as an advisor to the state legislature, commissioning analyses to better understand the causes and implications of the state's high costs for health care and developing a comprehensive set of recommendations for reform, issued in 2014.[1] The state elected to expand Medicaid coverage under the Patient Protection and Affordable Care Act (ACA) in 2015. Since that time, stakeholders have focused increasingly on how to realize health care's triple aim of improved population health through higher health care quality and greater cost savings for Alaskans.

The Alaska Healthcare Transformation Project. In the Spring of 2017 a Steering Committee met to develop a comprehensive health care plan for Alaska, with the objectives of aligning all payers toward value-based alternatives, increasing the percentage of Alaska residents that have a usual source of primary care by 15 percent, and lowering the per-capita health care growth rate to the greater of 2.25 percent or the Consumer Price Index (CPI) within five years. The formation and mission of the Steering Committee convey the state's commitment to providing high-value care to its residents. In the Spring of 2018, a group of strategy development teams, comprised of policymakers, providers, payers, and patient advocates, were convened by a Project Management Committee (PMC) to translate the Steering Committee's objectives into four statements of work (SOW), with priority for recommendations addressing five key topics: primary care utilization, coordinated care, payment reform, data analytics, and the social determinants of health.

NORC and its partners at UAA are preparing a set of four reports–one for each SOW–to provide analytical and research support that inform future decision-making around delivery system reform in the state. These reports are as follows:

- **Alaska Historical Project Scan.** Identify and assess selected delivery system reform experiments in Alaska over the past decade (2008 to the present), with priority to characterizing regional innovation within the state.
- **Alaska Studies—Meta-Analysis.** Identify and assess a group of Alaska-focused reports and studies issued over the past decade (2008 to the present) that concern health reform.

- **National Scan.** Develop case studies for selected states where delivery system reform relevant to Alaska's five key topics of interest offers lessons for prospective innovation.
- **Drivers of Health Care Costs and Spend in Alaska.** Review health care spending in the state and the prospects and limitations of available data sources that would support a fine-grained analysis of cost drivers relevant to these reforms. Based on this review, prepare a set of estimates of potential reform-related savings and a draft roadmap with proposed short-term (within one year) and long-term steps that comprise one or more pathways to reform.

Exhibit 1 below depicts the relationships among the four reports. Findings from the historical project scan and meta-analysis informing development of the national scan and cost drivers reports.

Exhibit 1: Four Reports Being Prepared by the NORC Team

Terms and definitions. The four reports being produced by the NORC team hare a common set of working definitions for the five key topics of interest. Exhibit 2 details the PMC's guidance on defining each topic and how the NORC has operationalized the guidance.

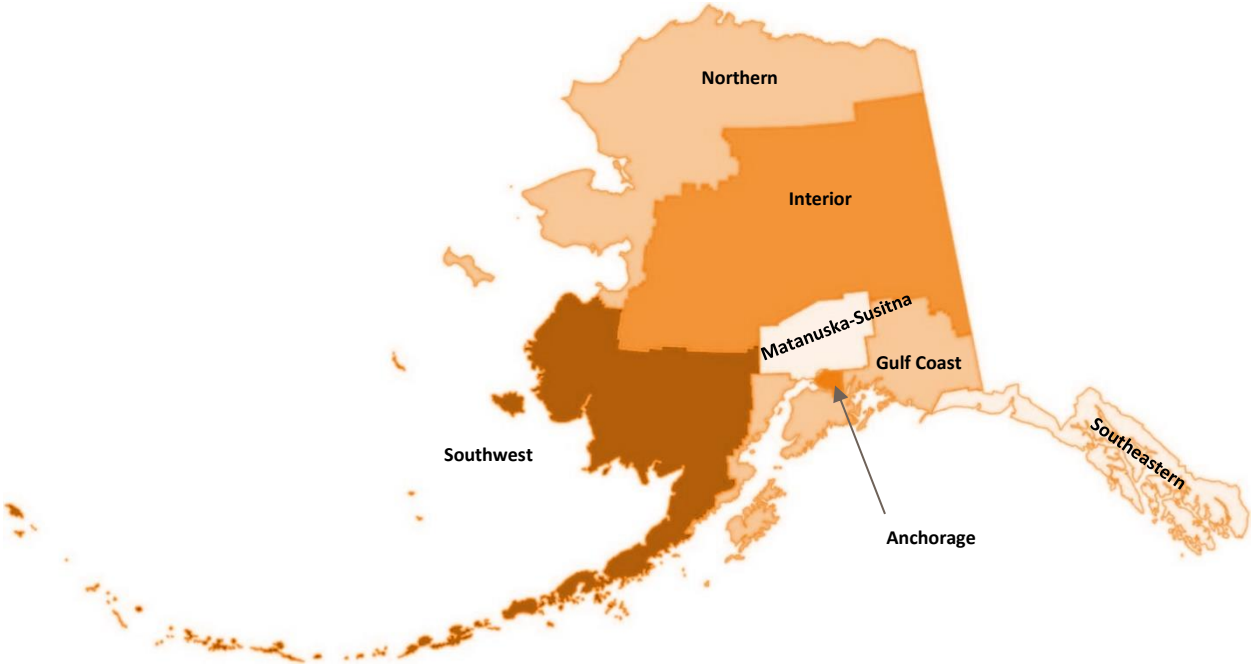
Exhibit 2: Key Topics of Interest

Term	Vision [from SOW]	Working Definition
Coordinated Care	A "system wide approach to patient centered whole person care" ▪ Primary care providers serve as care navigators across specialists, facilities, and provider groups ▪ Incentives support care coordination ▪ Coordination includes emergency care and emergency behavioral health	"…the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services." For a given patient at a given point in time, care coordination bridges gaps between or among care settings and typically involves sharing of information.[2]
Data Analytics	"system will support and be accessible to providers, hospitals, insurers, government payers, policymakers, and consumers" to support health reform [SOW]; ▪ All-payer claims database ▪ Professional staff with appropriate quantitative and qualitative skill to analyze data ▪ Data inform coverage decisions ▪ Quality and cost data are transparent to the public	"The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making."[3]
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" ▪ Value-based payments ▪ Priority list for health care services	'…payment methods that reflect or support provider performance, especially the quality and safety of care that providers deliver, and are designed to spur provider efficiency and reduce unnecessary spending."[4]

Term	Vision [from SOW]	Working Definition
	▪ Integrate evidence-based medicine into benefit design ▪ Standards for specific categories of service ▪ Leverage points in payment structures create incentives for change ▪ Reduce differences in payments across providers	
Primary Care	"team of health care professionals that together offer comprehensive whole patient care" ▪ Patients have usual source of care ▪ Patient engagement in management of their health ▪ Behavioral health integrated into primary care ▪ Increased supply of primary care providers ▪ Workforce practices at top of licenses	"the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[5]
Social Determinants of Health	"Social factors and physical conditions that shape whether individuals stay healthy or become ill."[6,7]	For Alaska, non-medical determinants operating at the level of the individual (age, gender, racial/ethnic identity), individual behavior (addiction; diet, nutrition, and exercise; sexual and reproductive health); social relations (connectedness/social cohesion and trauma); neighborhood, community, and region (access to clean water; incarceration; food and water, security, and housing), and at the state and national level. [7,8]

In addition, the PMC has defined the geographic regions of Alaska in terms of seven areas. See Exhibit 3 below for a visual depiction of these regions.

Exhibit 3: Seven Regions of Alaska



This Report. In the historical scan, we examine selected Alaskan health reform experiments (pilots, demonstrations, studies, and models) that have taken place since 2008. Our goal is to characterize the experiments, commonalities and differences among them, results, lessons learned, and prospects for

future delivery system reform. To begin this work, the NORC team submitted an initial list of health experiments for PMC review on November 5, 2018 (see Appendix B); a revised list was created to serve as the basis for in-depth analysis, primary data collection and analysis from document review, and a small number of key stakeholder interviews (see Appendix C for list of interview respondents to date).

This report opens with a short overview and summary of analytic methods, followed by a brief chapter on the historical context for recent health reform in the state. Three substantive chapters are next. The first is a top-level review of selected health reform experiments, organized chronologically and by type of organization leading and/or financing reform (tribal health organization, federal, and state). The second is a review of the same set of experiments, organized by PMC's five topics of interest; the review is situated in the context of an additional group of experiments for which limited information is available. The report closes with a third substantive chapter that presents key findings and themes about the health reforms. In addition, an initial set of observations about next steps is provided, both for the remaining reports that the NORC is preparing under contract to the PMC (e.g., national scan report, cost drivers report) and to consider as part of a draft roadmap for health reform in the state. The scope of this historical scan complements and overlaps with the scope of the meta-analysis prepared separately by the NORC team. For this reason, where feasible, the analyses in this report are coordinated with those presented in the meta-analysis report.

Finally, a set of appendices accompany this report. They include a glossary of acronyms and terms, a copy of the initial list of health reforms submitted to the PMC, more information about the interviews conducted as part of this SOW, and a set of matrices that present summary data about selected reform experiments.

Chapter Summary

The historical scan presented in this report offers a top-level view of recent reforms in the state, in the context of trends that date to the World War II era. It is not comprehensive, given the short timeframe for data collection and analysis. Rather, it is a top-level guide to the landscape of health reform in Alaska in recent years, gleaning lessons learned and noting gaps in our knowledge. We present findings from analyses of the experiments presented in this report as a foundation for subsequent project work assessing the quality of evidence about the experiments (meta-analysis); case studies of reform in other states; and a final report that presents a draft roadmap for health reform in Alaska.

Chapter Two: Methods for Historical Scan

In this chapter, we summarize our approach to preparing a historical scan of health reform in Alaska, 2008 to 2018. We lay out a set of definitions to guide our identification and analysis of documents. These definitions also ground the questions developed for the small number of interviews that our team is conducting with public figures active in Alaska health policy, as requested by the PMC.

Defining Terms to Identify and Describe Health Reform

In addition to setting out definitions for the five subject areas that comprise the topical scope of this report and the geographic regions to be compared, our analytic work is organized around a set of working definitions for several key terms, as summarized in Exhibit 4 below.

Exhibit 4: Defining Health, Health Care, and Health Reform

Term	Definition
Health	"…a dynamic balance of physical, emotional, social, spiritual, and intellectual health."[9]
Health Care	"…any care, treatment, service, or procedure to prevent disease, injury and other physical and mental impairment; and to maintain, diagnose, or otherwise affect an individual's physical or mental condition."[9]
Health Care System	"…a collection of organizations, practitioners and allied workers, facilities and technologies, financing mechanisms, policies, and information that provide and support the provision of health care for a population."[9]
Health Reform	Efforts to improve "Alaskans' health, enhancing patient and/or professional's experience of care, and lowering the per capita healthcare growth rate," either singly or in combination.[10] (Statement of Work from the PMC, 2018)
Health Outcomes	"Change in the health of an individual, group of people, or population that is attributable to an intervention or series of interventions"; these changes may relate to morbidity, mortality, functioning, well-being, and patient satisfaction.[11]
Health Services	Clinical care and services that support clinical care, that may include pharmacy, behavioral health, dental care, vision care, durable medical equipment, and medical transportation, as practiced by trained and licensed providers or those working under the supervision of a licensed provider.[12] (AKDHSS). Categories of health services include preventive or population-oriented (for example, vaccinations and screenings), primary care, secondary care (typically delivered by a specialist, including care received in a hospital emergency department), and tertiary care (specialty care received upon referral)

Payment Reform. To describe payment reforms in standard ways that align with developments in other states and nationally, we use the four-part alternative payment model (APM) framework created by the Health Care Payment Learning and Action Network.[13] The framework distinguishes delivery system reforms (such as patient-centered medical homes and accountable care organizations) from one or more payment reforms that may be used to effect delivery system change. The framework arrays four categories of payment reforms along a trajectory from (1) fee-for-service (FFS) purchasing without linkages to quality or value measures and (2) FFS with quality and/or value requirements (e.g., pay for reporting, pay for performance), to (3) shared risk models that employ FFS reimbursement (e.g., bundled payments for episodes of care) and (4) population-based payment models that reimburse for value rather than volume of care (e.g., global budgets).

Identifying a List of Health Reform Experiments.

NORC and ISER developed an initial list of 30 health reform experiments in Alaska that were active between 2008 and 2018. This list was based on a review of a set of reports and studies developed by ISER that comprised our initial list submitted to PMC under the meta-analysis task. In addition, our team searched websites of the Alaska Department of Health and Social Services, Alaska Health Care Commission, CMS Innovation Center, Rural Health Information Hub, the *Anchorage Daily News*, and Google. We used the set of definitions given in the preceding chapter as screening criteria for the search, for example, considering a health reform experiment to be the implementation of a new health care program, project, or model, or a substantial change to an existing health care policy or program, with the goals of improving patient and/or provider experience of care, improving the health of populations, and/or reducing the per-capita costs of health care. In addition, we restricted our search to initiatives targeted at one or more of the five focus areas identified by PMC: primary care, coordinated care, payment reform, data analytics, and social determinants of health. We focused on initiatives that began in 2008 or later, although we did include a few significant reforms initiated before 2008. Appendix B contains the initial list of experiments, submitted on November 5, 2018, to PMC.

Feedback from PMC, and receipt of additional reports and studies (for a total of just over 100 identified experiments), informed our selection of a priority list of 13 health reform experiments to be the focus of this report. We used two sets of screening criteria to assess relative priority of an experiment for our analysis: 1) region of Alaska in which the experiment took place, and 2) focus on at least one of the five topics of interest. For the assessment of reforms in each of the five topic areas, we supplemented the priority list with additional experiments from our revised list of 100 reforms, to enrich discussion, given the many gaps in information collected to date.

Data Collection, Analysis, and Reporting

NORC's team used a small number of semi-structured key informant interviews, together with online research and analysis of identified reports and studies, to characterize and compare selected health reform experiments.

Literature review and analysis. Online research began with in-depth review of reports and studies identified as described above, as well as review of relevant Alaska-specific websites and grey literature sources. We created an Excel template with domains that corresponded to the fields requested in the SOW for the historical scan and that facilitated comparisons by screening criteria and by each of the five key topics of interest. Data extracted from reviewed reports and studies were used to populate the template, with gaps noted. Narrative summaries were generated for each of the 13 priority experiments and the additional experiments identified for the five key topics of interest. These summaries became the core of several report chapters. In addition, the Excel template was used to generate a standardized set of health reform profiles—one page per experiment—that comprise Appendix D of this report. Throughout the process of analysis and report drafting, comparisons were made to the meta-analysis report being prepared at the same time, to align content and findings as appropriate.

Key informant interviews. The NORC team conducted four semi-structured interviews as part of report development. The list of prospective respondents was developed with guidance from the PMC; a list of interview respondents is given in Appendix C. NORC's Institutional Review Board (IRB) approved as exempt from human subjects research protections (classified as evaluation rather than research) both

the templates for outreach and follow up emails to prospective respondents and the interview protocol; these materials received reciprocal approval from the UAA IRB. Interviews were conducted by two-person teams at ISER and at NORC, with cleaned notes retained as a record of each interview. Interview notes were analyzed to supplement findings developed on the basis of the literature review. In addition, findings and themes from the interviews are expected to inform development of the other three reports being developed by the NORC team under contract with the PMC (e.g., meta-analysis, national scan, and cost drivers).

Reporting. An initial report outline was submitted for PMC review and feedback incorporated into a revised outline. A team at NORC drafted the report, using content developed through the literature review and key informant interviews. NORC team partners at ISER and ICHS reviewed the initial full report draft. Additional report reviews were conducted by senior leadership at NORC and a professionally copy edited version prepared for submission.

Chapter Summary

This historical scan represents a first step toward our project team's assessment of health reform options in Alaska. It endeavors to put current considerations in their historical context and sketch the landscape of reform efforts over the past decade (2008 through 2018). Our assessment is not comprehensive, given the short timeframe for the work, the substantial gaps in the documentary record, and the small number of key informant interviews feasible within this timeframe. Rather, it is designed to provide background observations that support the analytic work of the meta-analysis, national scan, and cost driver reports being prepared by the NORC team under contract with the PMC. Findings and themes identified from past experiments may offer lessons useful as Alaska stakeholders chart their health reform pathways forward.

Chapter Three: Context for Health Reform in Alaska

Reform experiments in recent years take place amidst the legacy of health services infrastructure created in previous decades. This chapter provides an overview of Alaska's health past, together with a profile of current demographics, socioeconomic status, and geographic distribution of its residents.

Past as Prologue: Health and Health Care Before 2008

"…Alaska is an enormous place…transportation and communication fifty years ago were expensive, unreliable, and often simply non-existent."[14]

The modern history of health in Alaska begins with the building of health services infrastructure and military installations in the 1940s and World War II. This was accompanied by a significant increase in population, especially around Anchorage and Fairbanks. Infectious disease had a significant impact on the health of Alaska's populations, especially for American Indians and Alaska Natives (AI/AN), peaking around World War II. The groundbreaking Parran investigative report on health in the state at mid-century (1954) noted a 40:1 ratio of TB incidence for Alaska Natives, compared with the US population overall.[14] The state's department of health created its TB division in 1946 and built the Alaska Native Health Center, which as devoted to care for TB patients, in 1953.

Experience with TB underscored the impact of non-medical or social determinants of health on Alaskans: substandard housing and significant food insecurity documented in the Parran report also marked this era and contributed to the prevalence and severity of communicable disease, and the burden and suffering that accompanied chronic illness, infant mortality, and shortened lifespans. Key developments in the 1950s and 1960s included the use of case-finding and antibiotics to stem tuberculosis, childhood vaccination campaigns, efforts to upgrade housing and deliver water and sewer services, trauma care to address high rates of unintentional and occupational injuries and premature deaths, and training Community Health Aides (CHAs) to deliver primary care in rural villages, starting in the 1950s.[15]

The 1960s and 1970s brought an infusion of funds from the new Medicare and Medicaid programs, as well as initiatives to address access to health care and social determinants of health. In addition, nascent civil rights and self-determination movements among the AI/AN population laid an important foundation for health services delivery and governance in Alaska. There was significant attention to addressing the lack of access to primary care, the building of hospitals and clinics, and a transition from infectious to chronic disease as a driver of population health concerns (e.g., diabetes overtakes tuberculosis).[16] Coordination across tribal and non-tribal health organizations was a signature experience cited by long-time health officials, specifically as health systems agencies were established, together with the certificate of need program, under 1974 federal legislation.

Current Context for Reform

Population. Alaska has a relatively small and diverse population. Recent data indicates a total population of almost 740,000 individuals (U.S. Census, 2017). About two-thirds of the population are identified as White (67 percent), with the remaining third split between American Indian/Alaska Natives (about 15 percent) and those identifying as two or more races (7 percent), Asian (5 percent), and Black (4 percent). The state is home to 229 federally recognized tribes with about 80,000 members and

approximately 150,000 Alaska Natives served by the tribal health system; this diverse population includes over 200 villages.[17] Demographically speaking, Alaska is a relatively young state, with a median age of 34.9 years, compared with 38 years for the United States overall, although the population of residents age 65 and older is growing at the fastest rate. Higher birth rates among Alaska Native communities skew the population younger, which also reflects the arrival of young and working-aged adults and families from out of state, and a small but growing population of older adults (11 percent of the state population is age 65 and older). Since the 1990s, the state has seen relatively stable growth in population, with Anchorage and the Mat-Su Valley anchoring for this growth, and an increase in racial and ethnic diversity.[18]

Population health. Cancer and heart disease rank as the top two causes of death with chronic lower respiratory diseases and accidents consistently in the top five. However, unlike the rest of the United States, suicide was between the fourth and sixth leading cause of death in Alaska from 1994 to 2013.[19] Across the United States, suicide was the 10th leading cause of death in 2016 and, although on the rise, has remained between the 15th and 10th leading cause of death since 1999.[20] In addition, substance abuse is a larger problem in Alaska than elsewhere in the United States, with death rates related to alcohol use and higher than the national average: the 2016 age-adjusted alcohol-induced death rate in Alaska is 141 percent higher than the U.S. average.[21] Relative to elsewhere in the United States, more adolescents in Alaska report experiencing depressive symptoms and episodes as well as suicidal thoughts, attempts, and related injuries.[22]

Overall, American Indians (AI) and Alaska Natives (AN) share many of the same challenges as those faced by tribes elsewhere in the United States.[23] These issues include cultural barriers, geographic isolation, inadequate sewage disposal, and low income. Heart disease, cancer, unintentional injuries (accidents), diabetes, and stroke are leading causes of death among AI/ANs. AI/AN populations also have a high prevalence of mental illness and suicide, obesity, substance abuse, sudden infant death syndrome, teenage pregnancy, liver disease, and hepatitis. AI/AN have an infant death rate 60 percent higher than the rate for Whites and are twice as likely to have diabetes as Whites. Death rates from unintentional injuries and suicide are also disproportionately high among AI/ANs. In 2012, the tuberculosis rate for AI/NAs was higher compared to the White population (6.3 vs. 0.8, respectively).

While in many ways Alaska's experience is similar to rest of the United States, there is diversity in how social determinants affect the state's unique population, with its substantial population of Alaska Natives and much of the population living in rural areas. At 10 percent, Alaska's poverty rate is below the national average of 14 percent. However, the poverty rate is higher in rural than urban areas (14 percent versus 8 percent).[24] A number of Alaska-specific factors likely influence this rate, including the annual permanent fund dividend paid to eligible residents, the presence of both cash and subsistence economies, and the current economic recession and decline in state revenues. The percentage of food-insecure households in Alaska is almost 12 percent, similar to the United States overall.[24] While the percentage of 18-24 year olds with a high school diploma or equivalency is about the same in Alaska as the rest of the United States (85 percent versus 86 percent), the rate for Alaska Natives is much lower (78 percent).[25] A recent report by the Alaska Housing Finance Corporation noted significant housing challenges for Alaskans, including overcrowding that is twice the national average and high costs of housing and household energy.[26] The rate of chronic homelessness in Alaska is 29 percent higher than the U.S. average.[27]

Rural geography. As the largest and least densely populated state, Alaska faces unique challenges in ensuring access to affordable health care services for its residents. Alaska's approximately 740,000

residents are spread across over 570,000 square miles.[28] With one metropolitan municipality (Anchorage) and two metropolitan boroughs, the state is predominantly rural and frontier.[29] Nearly one-third of the state's population live in a rural (non-metro area), which is higher than the national average of 14 percent.[30] Outside of the Anchorage metropolitan area, home to about 40 percent of the state's population, Alaska has less than one person per square mile, compared with 92 people per square mile for the United States overall.[28] Juneau, the capital, is located in the southeastern coastal region of the state. Long-time settlement patterns among AN communities have been along coasts and rivers.[18] Since the 1990s, migration from rural to urban areas has increased the size of population centers, while rural communities are sustained by the relatively younger AN populations. Tribal communities are distributed across the state, in sparsely populated territories with limited access to health care.

Transportation and communication remain signal challenges to health care delivery in the state. Two-thirds of the land mass is unreachable by road or ferry and is referred to as "remote rural."[31] Alaska's vast and varied geography, as well as remote communities, requires regular use of air transport —helicopter or fixed-wing aircraft—for emergency medical services. A recent GAO report found that the median helicopter air ambulance charged to Medicare doubled to $30,000 per transport from 2010 to 2014. Given the potentially high out-of-pocket costs to patients, many air ambulance providers in Alaska, as with providers in other rural communities, offer annual memberships to residents in their service areas.[32]

Governance in health care delivery. Perhaps owing to the remote distribution of much of the state's population, and the fact that about 15 percent of the population is AN and/or AI, administration of health care services tends to be either broad based (for example, with the state department of health carrying out functions that in other states would be conducted by county and municipal health authorities) or quite local, with tribal health organizations delivering care to Alaska Natives. The tribes in Alaska organize into Tribal Health Organizations to sign compacts with the IHS. IHS maintains eleven Title I contracts with Alaska tribes and tribal organizations, and IHS negotiates one Title V compact with 25 separate tribal funding agreements each year.[33] The Tribal Health Organizations are organized into 12 tribal health regions to manage delivery of health care services in the respective regions.[34] The Tribal Health Organizations join together to form the ANTHC. ANTHC and Southcentral Foundation jointly run the ANMC. ANMC provides tertiary care for the entire state and provides other kinds of health care services that the tribal health regions cannot provide. In additional, ANTHC provides a wide array of services to the Tribal Health Organizations and to Alaska Natives across the state. For example, ANTHC provides training for community health aides and other medical para-professionals who serve much of rural Alaska.

A key theme is that of tension between efforts to consolidate authorities toward greater alignment or consistency in policy approach and countervailing expressions of autonomy appears to be an enduring theme of health care governance in the state. The first approach can be seen in empaneling enough beneficiaries to enable a positive return-on-investment for a value-based purchasing model, while the second, can be seen in the history of compacting in the state. There are notable examples, both historical and contemporary, of multi-stakeholder partnerships that have been influential in the state's health policy:

- Under the National Health Planning and Resources Development Act of 1974, Alaskans were required to convene local health systems agencies to guide local use of resources, including allocation through the new certificate of need [CON] process for high-cost expenditures in facilities and equipment. Agencies were required to have geographic and consumer representation, and Alaska Natives participated in health systems agency-related planning. Long-time public officials involved in health care have emphasized the positive model and impact of health systems agencies, noting

"…those HSAs were the most creative period where Alaskans of all shapes came together and innovated…" (p.15, AKHCC Elders Convening)

- More recently, the state Department of Health and Social Services (AKDHSS) partnered with ANTHC to coordinate efforts around Healthy Alaskans 2020, part of a federally supported population health planning effort.[35] This multisector collaboration uses a framework grounded in data to identify opportunities to address social determinants of health, in order to improve health outcomes for all Alaskans.[36]

Health care delivery systems. Alaska is not unique among the states in having multiple health care systems—public, tribal, military, veterans, and private/nonprofit—that serve overlapping groups of residents (for example, those who qualify for veterans' benefits and Medicaid). But the sheer distances that separate populations and the concentration of beneficiary populations within the state give shape to a uniquely complex set of institutional and provider relationships.[37] The Alaska Tribal Health System (ATHS), a voluntary affiliation of nearly 40 tribes, is a critical element of the state's delivery system. Each tribal health organization within the ATHS is owned and operated independently, participating in a sophisticated referral system. The Southcentral Foundation (SCF) and ANTHC co-manage the Alaska Native Medical Center ANMC located in Anchorage. Beyond acute medical care, ANTHC also addresses workforce shortages through training paraprofessionals such as community health aides, behavioral health aides, and dental therapists, as well as public health by improving sanitation in rural areas through water and sewer construction. In addition, active duty military, reserve forces, military civilians, and veterans account for 100,000 state residents. The U.S. Army and U.S. Air Force each provide health care to these military and veteran populations.

Multiple payers for health care and the cost of care. About 45 percent of Alaska's population is covered by employment-based insurance, 22 percent through Medicaid, 9 percent under Medicare, 7 percent under military and/or veterans programs, and 3 percent under non-group or individually purchased policies (2017 data). Fourteen percent are uninsured.[38] There are about 184,000 Medicaid enrollees, some of whom have coverage through other payers. Nearly one-third (32 percent) of Alaska children are covered by Medicaid, as are about 20 percent of the state's Medicare beneficiaries.[39] In addition, Medicaid covers two-thirds (66 percent) of AI/AN children and over one-quarter (28 percent) of AI/AN adults.[40]

The cost of care for payers and consumers is higher in Alaska than in most other states. In 2014, Alaska had the highest per-capita healthcare spending at $11,064 (almost 38 percent above the U.S. average).[41] Between 1991 and 2014, Alaska's health care spending grew at a rate of almost 8 percent, almost two percentage points above the average U.S. growth rate.[41] Alaska features a complex landscape of payers: it ranks as the state with the lowest share of private-sector employers that offer health insurance (32 percent) and ANTHC's facilities serve as a de facto safety net for AN and their neighbors alike.[42] It also has the highest premium contribution by private-sector employees at $7,964, about 25 percent above the U.S. average.[42] In 2004, Alaska implemented a regulation that requires commercial insurers to pay out-of-network providers an amount that is at least as much as the 80th percentile of billed charges for that service in that geographical area. A recent study indicates that this 80th percentile rule could explain up to about one-quarter of the increase in health care expenditures the state has experienced over the last decade.[43]

Setting the Stage, 2008-2019: Legislative and Administrative Context for Reform

A one-year health reform study group created under Administrative Order 246 submitted its proposed strategic plan for Alaska in 2009. Within the year, the state legislature passed SB172, which would become Alaska Statute 18.09.010, creating the AKHCC as a multi-stakeholder advisor on payment and delivery system reform regarding acute medical care, including behavioral health but not long-term services and supports. Active from 2009 through 2015, AKHCC commissioned a series of analyses around reform options (among those detailed in the following chapters). In late 2014, it set out an eight-part roadmap for reform, organized around seven sets of policy and programmatic strategies, including five core recommendations (increase transparency, pay for value, engage and support employers, strengthen front-end care, and improve care for seriously ill patients) and three cross-cutting recommendations (ensure the best available evidence is used for making decisions, focus on prevention, and build the foundation of a sustainable health care system).[44]

The year 2015 was pivotal for health reform in Alaska. Expansion of Medicaid under the Patient Protection and Affordable Care Act (ACA) became a focus, with the Alaska Supreme Court ruling clearing the path for expansion in September 2015. There have been 46,967 lives covered by the Medicaid expansion, representing 23 percent of the state's total Medicaid population. The total summed reimbursement amounts paid for Medicaid expansion claims from November 9, 2015 to January 1, 2019, approached nearly $1.2 million.[45] In addition, the state used a section 1332 Medicaid waiver to preserve its health insurance marketplace through reinsurance reform. The ACA exchange has had only one insurer for the past two years and enrolled 18,313 people during the 2018 open-enrollment period.[46]

Chapter Summary

Much health reform activity of the past decade is rooted in the federally-financed infrastructure built in the years during and after World War II. Health policy at midcentury in Alaska, around the time of statehood (1959), emphasized addressing the spread of communicable disease, training of providers to begin to meet the needs of residents—many of whom lived in areas with little, if any, access to quality health care—and attention to mitigating the impact of several non-medical social determinants of health (namely, substandard housing, lack of access to potable water and sewerage, and food insecurity). Current-day policies, programs, and health care facilities also bear the imprint of Alaska's remote geography, climate and weather, and patterns of settlement, unique among the states, as seen in ongoing efforts to mitigate the challenges posed by the need to bring health care to patients and families or vice versa (e.g., medical transportation) and to collect and share information across great distances, whether by radio or more recently, as enabled by broadband internet service. The layers of Alaska's complex payer environment (e.g., tribal, federal, state, and commercial) and decentralized, overlapping delivery systems (e.g., tribal, private sector, and state) developed incrementally over decades in the state, and alongside these systems, groups of stakeholders and constituencies whose perspectives are critical to include and address in reform deliberations.

While the tension between provider autonomy and more centralized oversight—whether governmental or organizational more generally—is an important theme in Alaska's health history, another key theme is that of the value placed on cross-sector collaboration in strategic planning, particularly those that bring AI/AN and state partners jointly to the table. Two examples stand out from Alaska's past: that of the health systems agency planning and related certificate of need process that have guided decision-making about infrastructure investments starting in the 1970s, and the Healthy Alaskans 2020 consensus-driven

planning process to set population health goals. Both examples illustrate a middle path between autonomy and oversight that has demonstrated success for Alaskans. This context for Alaska's health past sets the stage for the review of selected recent health reform initiatives in the chapters that follows.

Chapter Four: Chronology of Health Reform in Alaska, 2008 to 2018: Selected Experiments

Eleven recent health reforms identified by the PMC offer insights into next steps for Alaska. Considered as a group, they underscore the leadership role played by the Alaska Native Tribal Health Consortium (ANTHC) in reform around primary care, the leverage toward reform created by federal dollars and through state administration of the Medicaid program, and the clustering of reforms in more urban parts of the state, specifically Anchorage, the Mat-Su Valley, and southeastern Alaska. We identified evaluation findings for six of the eleven experiments. To date, there is little or no peer-reviewed evidence to date that support sustaining, replicating, or scaling these reforms.

In this chapter, we present a top-level summary and analysis of these 11 reforms. For each, where known, we identify the region or regions where the initiative is active, the organization(s) leading the reform, the funding entity, the status, the topic or topics of interest addressed by the reform, population(s) targeted and/or served, and what we know about the outcomes. More details about each reform are included in a set of profiles in Appendix D. Analysis of each reform in the context of the five key topics of interest is presented in the chapter that follows this one.

Recent Health Reform Experiments in Alaska, 2008-2018

A summary matrix arrays the eleven reforms by region, leading entity, funder, status, and population(s) served; See Exhibit 5 below.

Exhibit 5: Matrix of Health Reform Experiments, 2008 to 2018

Name	Leader of the Initiative	Entity Providing Funding	Status	Topic	Population(s) Served	Health Services/Outcomes
Statewide Scope						
Complex Behavior Collaborative	AKDHSS	AKDHHS	Ongoing	Primary Care/ Coordinated Care	Medicaid enrollees	■ Of 42 participants, 32 (76%) avoided institutional care. ■ Of 42 participants, 39 (93%) have been able to stay in the community. ■ Of the 10 (24%) participants requiring a higher level of care, 7 have returned to the community setting.
Medicaid Coordinated Care Initiative	AKDHSS	National Governors Association	Ongoing	Primary Care/ Coordinated Care	Medicaid enrollees	■ The reduction in ED utilization experienced by AMCCI participants saved the Alaska Medicaid program over 8.5 million dollars in 2017. ■ Overall medical services utilization for these participants decreased by 9 percent.[47]
PCMH Initiative, including pilot	Alaska Primary Care Association (AKPCA)	Capital grant from AK State Legislature; AMHTA, AKDHSS	Ongoing	Primary Care/ Coordinated Care	Patients at clinics in Wrangell, Talkeetna, and Bethel for pilot; then statewide.	None demonstrated yet.
Transforming Clinical Practice Initiative	University of Connecticut, University of Washington	CMS	Ongoing	Primary Care/ Coordinated Care, Data Analytics	Medical group practices, regional health care systems, regional extension centers, and national medical professional association networks.	None demonstrated yet.

Name	Leader of the Initiative	Entity Providing Funding	Status	Topic	Population(s) Served	Health Services/Outcomes
Reforms Based in Anchorage and/or Matanuska-Susitna Valley						
Nuka System of Care*	Southcentral Foundation	IHS, multi-payer	Ongoing	Primary Care/ Coordinated Care	65,000 AI/AN in Anchorage and 55 rural villages	▪ 95% of members are assigned to integrated primary care team. ▪ Reduced average delay to schedule routine appointment from 4 weeks to same-day access. ▪ 36% reduction in hospital days. ▪ 42% reduction in ER and urgent care usage. ▪ 58% reduction in specialty clinic visits sustained over 10 years. ▪ Met 75th percentile of 75% of HEDIS measures (national standards). ▪ Met 95th percentile for diabetes care. ▪ In a 5 years, staff turnover has decreased by 25%. ▪ 25% increase in childhood immunizations. ▪ Customer satisfaction with respect for their cultures and traditions at 94%.
FQHC Advanced Primary Care Practice Demonstration	Anchorage Neighborhood Health Center	CMS	Complete	Primary Care/ Coordinated Care	195,000 Medicare beneficiaries in Anchorage	▪ While evaluation results specific to AK are not available, national results from 503 participating sites found the following: ➢ 70% of sites achieved NCQA Level 3 PCMH recognition (relative to comparison sites). ➢ Over time, beneficiaries at recognized FQHCs had better utilization, process, and cost outcomes; however, outcomes were largely mixed.
Strong Start for Mothers and Newborns Initiative*	Juneau Family Health and Birth Center, Geneva Birth Center, Mat-Su Birth Center, and Windsong Midwifery/The Birth Place	CMS, HRSA, ACF	Complete	Primary Care/ Coordinated Care	Medicaid enrollees in Anchorage and Mat-Su Valley	▪ Across the 27 awardees, Medicaid beneficiaries enrolled in the Birth Center Model had lower rates of preterm birth, low infant birth weight, and cesarean section compared to similar Medicaid programs not enrolled. ▪ The program also lowered care utilization and costs: compared to similar Medicaid beneficiaries not enrolled, costs from birth through the first year of life were $2,010 lower for Medicaid beneficiaries enrolled in the program. ▪ Program enrollees also had less infant emergency visits and hospitalizations. ▪ Outcomes specific to AK sites are not available; however, the Birth Place and Mat-Su Birth Center, both in Wasilla, had 403 and 128 participants with data, respectively.

Name	Leader of the Initiative	Entity Providing Funding	Status	Topic	Population(s) Served	Health Services/Outcomes
Bundled Payments for Care Improvement: Models 2 and 3*	The Alaska Hospitalist Group/ Providence Family Medical Center	CMS	Ongoing	Payment Reform	Medicare beneficiaries in Anchorage	▪ Nationwide, Medicare FFS payments decreased, although overall spending increased as a result of reconciliation payments made to participants. ▪ Of those who received acute care, fewer were discharged to an institutional setting. ▪ Patients in SNFs had shorter stays relative to comparison groups. ▪ Bundled payments could improve quality of care for maternity and newborn care, although other payment policies could damper effects.[48]
Other Regional and/or Local Reforms						
Prince of Wales Health Network	Southeast Alaska Regional Health Consortium, Alicia Roberts Medical Center, state of Alaska Craig Public Health Center, Community Connection, Alaska Island Community Services (AICS), PeaceHealth Medical Group Prince of Wales, Whale Tail Pharmacy, and Southeast Dental Center.	FORHP, AK Community Foundation	Ongoing	Primary Care/ Coordinated Care SDOH	Residents of Prince of Wales Island	None demonstrated yet.
Kodiak Area Native Association (KANA) Electronic Clinical Reminders*	KANA	IHS	Complete	Data Analytics	Kodiak natives and residents of 6 surrounding villages	▪ Data from 2007-2011 show screening rates for all 5 measures (depression, tobacco cessation, intimate partner violence, alcohol abuse, and cardiovascular disease) improved considerably, to levels significantly above the national average for IHS facilities.
Health Care Innovation Award*	Peacehealth Ketchikan Medical Center	CMS	Complete	Primary Care/ Coordinated Care	12,800 Medicare beneficiaries	▪ Care coordinators contacted 60-80% percent of all patients discharged from the PeaceHealth hospital. ▪ Statistically significant improvement in processes-of-care, driven solely by a 12 percentage point (or 57%) increase in the percentage of patients with diabetes who received all four recommended diabetes process-of-care measures.

NOTE: * indicates that at least one published evaluation has been identified and reviewed.

Regional Distribution of Reforms. Four of the reforms are statewide in scope—three related to the Medicaid program and one (the Transforming Clinical Practice Initiative) related to capacity building in the areas of data analytics and the healthcare workforce. Another four reform efforts are located in or near the population centers of Anchorage and Matanuska-Susitna Borough, including Southcentral Foundation's Nuka System of Care and three demonstrations funded by the Centers for Medicare and Medicaid Services (CMS). In addition, there are two reforms based in Southeastern Alaska (Prince of Wales Health Network and PeaceHealth Ketchikan Health Care Innovation Award). None of the highlighted reforms are located in the Northern or Interior regions of the state.

Leadership of Reforms. Most reforms are led either by tribal health organizations or by providers under agreement with state agencies (most often, the Alaska Department of Health and Social Services) (AKDHSS).

Entities Funding Reforms. Federal dollars and programs support most of the reforms selected. Nearly half (five of the eleven) are funded by CMS.

Topics of Reform. Nine of the eleven reforms highlighted here are focused on primary care and coordinated care, with payment reform and data analytics each represented by one reform initiative, respectively.

Populations Served by Reforms. We know more about the identity of residents to be served by reforms and less about the actual number targeted or actually engaged, as patients, family members or caregivers, or as members of the general public intended for outreach or health education as part of reform. The highlighted reforms serve Medicaid enrollees, Medicare beneficiaries, AI/AN residents served through tribal health organizations, and groups defined geographically, for example, those served by specific clinics or empaneled to receive care through a particular reform model.

Outcomes. We lack validation for much of what is documented about these reforms; the NORC team identified program evaluations or peer-reviewed publications specific to Alaska for six of the eleven initiatives. Southcentral Foundation's Nuka system offers the most evidence to date of effectiveness, with findings of more appropriate care (in the case of managing diabetes), greater customer-owner satisfaction, reduced inappropriate ED utilization and hospital readmissions, and cost savings. Evidence about other reforms is limited but promising: positive findings are seen for the Complex Behavior Initiative and the Coordinated Care Initiative's emergency room diversion program. The Kodiak Area Native Association's use of electronic clinical reminders was associated with improved screening rates for preventive care and PeaceHealth Ketchikan's care coordination pilot with improved care process measures for diabetes. National evaluation findings that included data from Alaska sites identify improved in utilization, process of care, and cost outcomes (FQHC Advanced Primary Care Practice Demonstrations), improved quality of care and cost savings (Bundled Payments for Care Improvement Models 2 and 3), and improved outcomes for pregnant women and their infants (Strong Start for Mothers and Newborns). However, the generalizability of these findings from national to local sites is unclear.

Gaps in Reform. While many reforms have been launched in the past decade, and the pace of reform has accelerated with enactment of SB74, there are many regions, populations, and outcomes not encompassed by this list of eleven reforms. Regions favor those more densely populated and toward the southern end of the state. Initiatives led by or funded by the Department of Defense or the Veterans' Administration are not included. For the most part, these reforms do not address dental and vision care,

access to durable medical equipment, the broader field of long-term services and support, or institutional, residential care. There are few payment reforms other than bundles and capitated monthly payments, and few delivery system reforms other than PCMH and a small number of risk-sharing models (accountable care and managed care health plan).

Chapter Summary

The top-level description of 11 health reforms given priority by the PMC offers a hint at the diversity of initiatives launched in the past decade and of the need for evidence-based assessment and evaluation of these reforms. To date, the NORC team has identified and validated relatively little information about each reform, based on our literature review and a small number of key informant interviews.

In the chapter that follows, these eleven reforms are analyzed in greater depth, putting each in the context of one or more of the five topics of interest articulated by the PMC. Given the limited information available for these reforms and the many gaps in evidence regarding findings, our assessment looks at reform as part of a group of initiatives for each topic, drawing from a list of approximately 100 initiatives identified as part of the initial list submitted to the PMC; see Appendix B. Considering a larger group of reforms for each topic enables a more coherent approach to describing the landscape of reform in Alaska.

Chapter Five: Health Reform Experiments by Topic

In this chapter, in-depth analyses are presented for each of the five key topics of interest to the PMC. For each topic, we offer background or context for the reforms assessed in the past decade, looking at the time period before 2008. Next is a descriptive review of a set of reforms, including the eleven prioritized by the PMC, to better understand the types of approaches to reform and identify key findings related to structural and governance considerations, stakeholders, gaps in reforms, strengths of and barriers to reform, and the potential for reforms to be replicated and/or scaled. These findings are synthesized across topic areas in the chapter that follows.

Primary Care Utilization and Coordinated Care

The Alaska Health Care Commission organized many of its 2014 recommendations around primary care and coordinated care reform. The fifth of eight core strategies gives a detailed blueprint for primary care reform, specifying that "definitions, measures, outcomes, and payment models" focus on PCMH models, as well as the integration of behavioral health into primary care. In its assessment of reforms, the AKHCC identified seven strategies that characterized successful launch of primary care models, as well as six common attributes of successful primary care reforms, namely available resources, access to new tools and training; shared learning environments; timely data analytics; clinical medical support for staff; and systematic quality improvement.

Strategies Common to Successful Launch of Primary Care Reform Models

- Financial investment by initiating payer(s)
- Strong medical leadership and management
- Collaboration between payer(s) and clinical provider(s)
- Vision centered on care that articulates principles, definitions, criteria for participation, and tools and measures
- Local or practice-level focus that prioritizes flexibility and empowerment
- Phased implementation
- Tiered management of patient populations

Source: AKHCC, 2015.

Much of the health reform since 2008 has incorporated one or several of these strategies, although evidence has yet to be developed from these relatively recent initiatives.

Reforms before 2008

In 1997, the Indian Health Service (IHS) transferred responsibility for delivering health services to the Southcentral Foundation (SCF), a nonprofit that now owns and manages health care for AI/AN residents in Anchorage, the Mat-Su Valley, and surrounding rural villages. SCF turned this payment reform into a homegrown patient-centered medical home (PCMH) model known as the ***Nuka System of Care***, launched in 1999. Nuka implemented a patient-centered approach to care based on a positive, holistic definition of health as wellness, considered in terms of physical, mental, emotional, and spiritual aspects.[49] SCF officials describe the Nuka System as centered about (1) recognition of patients as customer-owners with whom the delivery system is in partnership, (2) same-day access to care, and (3) integrated care teams that coordinate care and build long-term, therapeutic relationships with their empaneled customer-owners. These reform features are supported by robust health information technology (IT) and data analytics that inform care delivery and priority given to hiring and training customer-owners as staff.[50] SCF is supported by multiple funders that are nearly equally split between third-party payments (49 percent) and

IHS prepaid dollars (43 percent). Implementation brought with it an almost fourfold increase in costs in the first decade; however, SCF was able to significantly increase third party payments, for example, from $30 million to $220 million in the first six years of the model (1998 to 2004).[51]

In addition, efforts related to clinics and to health workforce are noteworthy aspects of delivery system reform prior to 2008. The first—federally financed health clinics—include Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHCs). The FCHC program, established in 1991 under Section 330 of the PHS Act, supports nonprofit or public facilities that increase access to care for underserved areas; they may also include outpatient health facilities operated by tribal organization or urban Native organizations.[52] Under Medicare and Medicaid, FQHCs receive cost-based reimbursement for specified services.[52] Data from 2014 there are 27 provider agencies operating in 148 service delivery sites.[36] In addition, in past years, Alaska has been home to a small number of RHCs, under a federal program established in 1977 (the Rural Health Clinic Services Act PL 95-210) to increase access to healthcare in rural areas through a variety of settings (e.g., for-profit or nonprofit, standalone or provider-based) and in particular, to support mid-level practitioners (NPs and physician assistants) through cost-based reimbursement for specific services under Medicare and Medicaid.[53] To qualify as an RHC, a clinic must meet specific requirements with regard to location, staffing, and services provided.[54, 55] Given the higher reimbursement through IHS for FQHCS than for RHCs, there has been relatively modest take-up of RHCs, and at present none are operating in the state.[36]

As of 2016, there were 806 primary care physicians in the state, concentrated in urban areas.[56] There are nearly as many licensed mid-level providers such as physician assistants and nurse practitioners (about 700); and a shortage of pharmacists. The state of Alaska has a large Public Health Nursing services program. These agencies provide clinical services to approximately 300 communities and villages on a sliding fee scale.[36,57] Another essential primary health service offered in Alaska is the Emergency Medical Services (EMS), which serves the state's vast geography and remote communities.

Addressing shortages of health care providers is an integral part of this story. Alaska developed the ***Community Health Aide Program (CHAP Model)*** in 1968 to fill the gaps in access to primary care. The program grew to target approximately 170 rural villages in the state with 550 CHA/Ps. Under this model community health workers collaborate with providers to offer high-quality care.[58] For the purpose of this report, related health workforce initiatives that address primary care, as well as dental services, behavioral health, and physician training, are considered as reforms that increase access to quality health care, as part of the social determinants of health topic area.

Reform, 2008 to 2018

In the following section, we review a group of health reforms identified as addressing improvement of primary care utilization and care coordination in Alaska; see Exhibit 6 for a list of these reforms. As noted earlier in the report, this list is not comprehensive. It includes a small number of reforms of interest to PMC, as well as experiments identified through our systematic review of published and grey literature.

Exhibit 6: Selected Reforms in Primary Care and Care Coordination, 2008 to 2018

Name	Leader of Initiative	Entity Providing Funding	Status	Population(s)	Health Services
Statewide Reforms					

Name	Leader of Initiative	Entity Providing Funding	Status	Population(s)	Health Services
Colorectal Cancer Screening Patient Navigator Demonstration Project	ANTHC	CDC	2005+	AN/AI	Prevention
Complex Behavioral Collaborative	**AKDHSS**	**AKDHSS**	**2012+**	**Medicaid enrollees**	**Primary care**; **behavioral care**
AK Medicaid Coordinated Care Initiative (MCCI); Super-Utilizers program targeting ED, expanded under SB 74 reforms as primary care case management system	**AKDHSS**	**National Governors Association**	**2014+**	**Medicaid enrollees**	**Primary, secondary, and tertiary care**
AK-PCMH-I Initiative	**AKDHSS and AKPCA**	**Capital grant from AK Legislature**	**2014-2019**	**Medicaid enrollees**	**Primary and secondary care**
Section 1115 Behavioral Health Demonstration Waiver	AKDHSS	CMS	2018+	Medicaid enrollees	Primary care; behavioral health
Reforms Based in Anchorage and/or Mat-Su Valley					
Nuka System of Care	**SCF**	**IHS, Medicaid, commercial, grants**	**1998+**	**65,000 AI/AN in Anchorage and 55 rural villages**	**Preventive, primary, secondary, and tertiary care**
FQHC Advanced Primary Care Practice Demonstration	**Anchorage Neighborhood Center**	**CMS**	**2011+**	**Medicare beneficiaries**	**Primary care**
Strong Start for Mothers and Newborns Initiative	**Joint effort by CMS, HRSA, and ACF.**	**CMS, HRSA, and ACF**	**2012-2016**	**Pregnant/post-partum women, infants at four urban birth centers (Anchorage, Juneau, Wasilla)**	**Prevention**; **primary care**
High-Utilizer Mat-Su Program (HUMS)	LINKS/ADRC	Mat-Su Foundation	2018+	Residents of Mat-Su Valley	Primary and secondary care
SB 74: Coordinated Care Demonstration Project [CCD]: managed care model by United Healthcare (Anchorage and Mat-Su); PCMH model by Providence Family Medicine (Anchorage)	AKDHSS	AKDHSS	2016+	Medicaid enrollees	Primary care
Other Regional and/or Local Reforms					
Frontier Extended Stay Clinics	CMS	CMS	2010-2013	Benes served by 4 rural clinics	Primary care
Ukudigatunal Wellness Center	AKNTHC	IHS	2011-2012	IHS beneficiaries in Aleutian Islands	Prevention; primary care

Name	Leader of Initiative	Entity Providing Funding	Status	Population(s)	Health Services
Early Childhood Comprehensive Systems Impact Project, Help Me Grow	AKDHSS; All Alaska Pediatric Partnership	HRSA Grant [59]	2016-2021	Children living in Norton Sound Region, Matanuska-Susitna Borough, Kodiak Island	Prevention
PCMH Pilot Program	**AKDHSS, Alaska Primary Care Association, AMHTA**	**Capital grant from AK Legislature**	**2011-2014**	**Rural and frontier populations, CHCs in 3 communities: Talkeetna (Mat-Su), Wrangell (Southeast), Bethel (Southwestern)**	**Primary care**
Peacehealth Ketchikan HCIA	Peacehealth Ketchikan Medical Center	CMS	2012-2015	Ketchikan and Craig (Southeast)	Primary care
Prince of Wales Island Health Network	Prince of Wales Health Network	FORHP, AK Community Foundation	2008+	Residents living on Prince of Wales Island (Southeast)	Prevention; primary care

NOTE: Reforms in bold are among the eleven that the PMC has prioritized for assessment.

Patient-Centered Medical Home Models

Since 2008, the Nuka System has continued to set the pace for primary care reform in the state. It was certified as a Level 3 PCMH in 2010 and remains an internationally renowned example of successful reform. The model coordinates delivery of medical, dental, behavioral, and related health care support services to more than 65,000 residents, or about one-third of the state's AI/AN population, with referrals to the Alaska Native Medical Center (ANMC) in Anchorage, co-owned by SCF and ANTHC.[51,60] Peer-reviewed evaluation findings of the Nuka system to date identify improved outcomes, including a 40 percent decrease in ED visits and a 36 percent decrease in hospital stays (2000 to 2017)[61] and improved management of Type II diabetes care, as seen in five monthly measures of care quality (1996 baseline to 2009).[62]

The ***Ukudigatunal Wellness Center (UWC)*** has tested a set of quality improvement reforms in a remote Alaska Native primary care clinic serving the Pribilof Islands and the Western Aleutian Islands. These reforms were part of the IHS's ongoing participation in the Institute for Healthcare Improvement's Improving Patient Care collaborative (subsequently the Quality and Improvement Learning Network). The Center was active for 18 months between 2011 and 2012 and was funded by federal appropriations and by federal and state grants. The goals of the reform were to improve both screening and management of chronic conditions. Unpublished research on implementation of the UWC finds mixed successes, with improved screening for preventive measures (tobacco use, documentation of BMI, and domestic violence, alcohol, cervical cancer, and blood pressure screen) and goals met for lipid control and for using quality improvement protocols to improve clinic processes around screening. Goals for patient care process measures around diabetes assessment were not met, nor were goals related to controlling blood pressure or long-term blood sugar (HgbA1C).[63]

The PCMH model has been a major focus for reform in the state.[64,65] In **2011**, the Alaska legislature approved a capital grant to support a three-year ***Patient-Centered Medical Home Pilot Demonstration*** at three community health centers in rural and remote locations: Alaska Island Community Services in Wrangell, Sunshine Health Clinic in Talkeetna, and Bethel Family Clinic. Our team has not identified

data on outcomes of this demonstration.[66,67] The following year **(2012)**, the state legislature allocated a capital grant to the Alaska Primary Care Association (AKPCA) to support transformation of federally funded community health centers into PCMHs across the state. The AKDHSS and AMHTA contributed additional funds. The first phase (***AK-PCMH-I***) was launched in 2014 and is anticipated to run for five years.[66] Each pilot site has received a one-time grant of up to $75,000 over 18 months, to support practice transformation related to behavioral health integration, for practices with existing health information technology (HIT) infrastructure.[67] Patients to be served include those living with significant mental health morbidity. Grantees are expected to secure PCMH accreditation under one of three national programs (NCQA PPC PCMH, Joint Commission, or Accreditation Association for Ambulatory Health Care). As of 2015, five practices had received awards.[68] Although no data are available yet, AK-PCMH-I is expected to evaluate the program using EHR data, satisfaction surveys, provider records, and claims data to evaluate five outcomes: improved health care access, health outcomes for patients, improvements promoting long-term cost savings, enhanced patient satisfaction, and enhanced practice satisfaction.[67]

Starting in **2014**, AKDHSS has led the ***Alaska Medicaid Coordinated Care Initiative*** (AMCCI) with funding from the National Governors Association.[69] The initiative aims to provide one-on-one case management to AK Medicaid beneficiaries with high health care utilization and complex needs.[70] Case managers provide participants with care navigation, support them in making healthy choices, assist with addressing barriers to care as well as obtaining referrals to specialists, manage chronic conditions through early identification, and improve compliance with medication/care plans. The program is voluntary and seeks to forge collaboration between case managers and providers, who may refer Medicaid members to the program. Case managers assist Medicaid members with selecting a primary care provider, hospital, pharmacy, and when appropriate, a behavioral health provider. Additional services provided include: telephone case management; initial screening; comprehensive health assessments; health education (e.g., tobacco cessation); and facilitating access to community resources, such as housing.[69] To provide these services, the AKDHSS has contracted with MedExpert and Qualis.[70]

Medicaid reform under SB74 includes ***Coordinated Care demonstrations*** to test payment options that support primary care delivery system reform. Two demonstrations are in the early stages of planning and implementation, both to be financed in part through per-member-per-month payments. These include a PCMH model to be fielded by the Providence Family Medicine Center, for Medicaid enrollees in the Mat-Su Valley, Kenai Peninsula, and the Anchorage areas.[71] The second is a Medicaid managed care plan that UnitedHealth Care will test in urban parts of the state (the Mat-Su Borough, Anchorage Municipality, Juneau City and Borough, and Fairbanks Borough). Projected annual savings are expected to reach $17.5 million in Medicaid savings and $30.4 million in administrative savings during the first three years of the project.[72]No evaluation findings are available to date.

Behavioral Health Integration with Primary Care

Behavioral health and substance abuse disorder treatment have become state as well as national priorities for payment and delivery system reform. In 2009, the Alaska Mental Health Trust Authority (AMHTA) and the state contracted with Western Interstate Commission for Higher Education (WICHE) to examine how Alaska served Medicaid clients with complex needs and challenging behaviors. WICHE found major gaps in the continuum of care, related to specialized training support for service providers, short-term stabilization of clients, and medium-term intensive intervention. In 2012, the Alaska Department of Health and Social Services (AKDHSS) launched the ***Complex Behavior Collaborative*** pilot.[73] It is a statewide initiative that offers training and consultation to providers who serve Medicaid clients with

complex mental health needs, as well as support to clients' family members. The program's goal is to help clients live as independently as possible, avoiding the Alaska Psychiatric Institute, ERs, jail, or out-of-state care. It also aims to improve the quality of life of Alaskans with complex needs, achieve cost savings for the state, and develop a competent workforce in Alaska and a strong infrastructure for continuity of care and collaborative interventions. Some of these services may include case-specific consultation, agency wide training, service completion plan, transition planning, functioning behavior assessment with a behavioral plan, and hands-on training for direct care providers and families.[74] 42 participants have been served in this collaborative. Of these 42 participants, 76 percent avoided institutional care and 93 percent have been able to stay in the community. Of the 10 participants that required higher levels of care, 70% returned to the community setting. Additionally, an initial evaluation has found that the collaborative has reduced behaviors that present a danger to others, non-threatening behaviors that constitute a significant problem, and behaviors that put participants at risk of moving to a higher level of care. It has also seen an increase in behaviors that allow participants to develop normal routines and that help participant's manage their own schedule and be self-directive.

More recently, in November 2018, the state has received a **Medicaid Section 1115 Behavioral Health Demonstration Waiver**, with the goals of shifting more care from acute, institutional settings to the regional or community level.[75] The waiver seeks to reduce use of hospital inpatient and emergency department care, preventing functional impairment, and reform the delivery system to improve accountability regarding treatment for substance abuse. Given the waiver's recent approval, there has not been any documentation of cost or population-based outcomes.

Emergency Department Utilization

The state has implemented successive reforms to address over-utilization of hospital emergency departments (EDs) by Medicaid enrollees, improve care coordination and reduce Medicaid spending. Under the state's Coordinated Care Initiative, starting in late 2014, a "Super-Utilizers" initiative has used care coordinators and referrals made either by telephone or in-person for frequent ED users. An expanded Emergency Department Coordination (EDC) Project has been implemented under the aegis of Medicaid reform (SB74), based on Washington State's ER Emergencies project.[76] It is a collaborative effort between the Alaska State Hospital and Nursing Home Association (ASHNHA), the state of Alaska, and the AK Chapter of the American College of Emergency Physicians (ACEP). The project is implementing real-time electronic exchange of patient information (the ED Information Exchange, or EDie), including data on ED visit, hospital care plans, and data on from the state's Prescription Drug Monitoring Program (PDMP). In 2017, the electronic ED system went live at four Providence hospitals; ED departments received flags identifying high ED utilizers and providers could access care/treatment plans. The project also promoted patient education about appropriate emergency room use, connecting patients with primary care or behavioral health providers post ED visit, and establishing statewide guidelines for narcotics prescribing in an effort to reduce drug-seeking and drug-dispensing to frequent ED users.

The ***High Utilizer Mat-Su Program (HUMS)*** created in January 2018 by the Matsu-Health Foundation sought to improve care coordination in order to decrease the inappropriate use of emergency department and emergency medical services in the Mat-Su region.[77] HUMS is creating customized patient-specific care plans that will be immediately available to emergency service and outpatient providers throughout the state, will improve communication and care management of all entities involved in a patient's care, and will reduce cost of care per patient, improving resource utilization.

Care Coordination Systems

Three Alaskan reform efforts to develop systems-level approaches to care coordination include the Prince of Wales Health Network, the Early Childhood Comprehensive Systems Impact Project, and Alaska's piloting of the national Help Me Grow program for young children.

On Prince of Wales Island, a group of community organizations created a network to increase access to high-quality health care for residents, most of whom are Tlingit. Like the Nuka system, the ***Prince of Wales Heath Network*** (POWHN) starts with a holistic, positive definition of health and wellness and focuses on primary care, care coordination, and SDOH. The model focuses on improving primary care by connecting local healthcare providers such as pharmacists, community health workers, and nurses; spurring the development of health infrastructure; and facilitating communications and data-sharing among stakeholders.[78] Specific priorities include youth leadership, supporting elder and adult care needs, addressing adverse childhood experiences, and opioids. Funding has come through grants from the Federal Office of Rural Health Policy (FORHP), state behavioral health dollars (a four year, $900,000 grant awarded in July 2014), and annual giving from member organizations, under the Alaska Community Foundation. We have not identified any evaluation, either underway or completed, to date, to enable assessment of model processes or outcomes, including any cost savings, and insights into whether or how to further refined, replicate, or scale this model.

The ***Early Childhood Comprehensive Systems Impact Project*** (ECC) is being implemented by Banner Health Fairbanks Memorial Hospital; Tanana Valley Hospital, Alaska Regional Hospital, AKDPH, AKDHSS, The Children's Hospital at Providence, Mat-Su Regional Medical Center, and ANMC. It has focused on four initiatives to address gaps in children's healthcare: organizing care through a PCMH model and providing immunizations and vaccinations, neurodevelopmental services, and initiatives to foster greater awareness about child abuse.[79] Our team was not able to identify evaluation findings available to date for the ECC project.

Help Me Grow (HMG) Alaska, launched in January 2018, is a multi-year initiative to engage providers, families, and communities, in order to field questions and concerns about childhood development, conduct developmental screenings, and make appropriate referrals. The All Alaska Pediatric Partnership is supporting launch and implementation of HMG Alaska, in partnership with Alaska's Child Care Resource and Referral Network and three ECC communities (in the Mat-Su Valley, Kodiak area, and Norton Sound region). In its first year, HMG Alaska served approximately 200 children and their families from throughout the state.[80]

Clinic-Based Reforms

Between 2010 and 2013, four primary care clinics in remote area—Alicia Roberts Medical Center, Cross Road Medical Center, Haines Health Center, and Iliuliuk Family and Health Services—operated as ***Frontier Extended Stay Clinics (FESC)***, supported by CMS cooperative agreements with Medicare-certified providers.[36] The FESC designation allowed each clinic to provide and be reimbursed for monitoring and observing Medicare and Medicaid beneficiaries for a limited period of time, to improve patient safety and quality of care.[81] Evaluation findings documented improved patient experiences and identified potential reduced Medicare costs related to transportation and hospitalization.[82]

In **2011**, CMS and HRSA jointly sponsored the ***Federally Qualified Health Center (FQHC) Advanced Primary Care Demonstration*** at the Anchorage Neighborhood Health Center, awarding a $3.8 million

grant. The demonstration tested the effectiveness of team-based coordination in improving primary care delivery and management of chronic conditions for Medicare beneficiaries and was part of a nationwide CMS effort to testing the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 patients.[83] The Center was paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services; in addition, it was expected to achieve Level 3 PCMH recognition and to adopt care coordination practices recognized by the National Committee for Quality Assurance (NCQA). The demonstration served 12,753 patients, about 12 percent of whom were children; over half were racial/ethnic minority group members (56 percent) and the rest identified as non-Hispanic whites.[84]

The following year (**2012)**, two providers in rural southeastern Alaska—the ***PeaceHealth Ketchikan Medical Center*** and PeaceHealth Ketchikan Medical Group—partnered to win a four-year, nearly $3.2 million ***CMMI Health Care Innovation Award***.[85] Their innovative model had the goal of improving primary care coordination for Medicare fee-for-service (FFS) patients with chronic disease at two clinics, using a nurse practitioner and four care coordinators to extend the reach of clinician teams. The model included workforce development, with plans for medical office assistant training through the University of Alaska Southeast, Ketchikan Campus. For the 600 patients who received care through the model, the demonstration yielded improved follow-up after hospital discharge, increased outpatient access to the clinics, and decreased referrals to the ER; in addition, an independent evaluation identified approximately $3.4 million in Medicare savings over the demonstration. The same evaluation found significant improvements in the quality of care for patients with diabetes, as measured by a 12 percentage point increase in four measurements of process-of-care, a focus for the innovation. In addition, a survey of clinicians who participated in the demonstration reported improved quality of care, timeliness, patient safety, and patient-centeredness.[86]

In **2012**, four Alaska birth centers joined the four-year ***Strong Start for Mothers and Newborns Initiative***, supported by ACF, CMS, and HRSA. Strong Start tested three care models to reduce the rate of preterm birth and low birth weight infants for CHIP beneficiaries at high-risk for these outcomes and to reduce Medicaid costs from pregnancy through an infant's first year.[87] The Alaska sites—the Juneau Family Health and Birth Center, Geneva Woods Birth Center (Anchorage), Mat-Su Birth Center (Wasilla), and Windsong Midwifery/The Birth Place LLC (Wasilla) — tested the Birth Center Model of care, comprised of care coordination (collaborative practice, intensive case management, peer counseling, psycho-social support) and referrals. A cross-site evaluation found that three of the four sites successfully implemented the model and served a total of 8,806 enrolled patients, and Medicaid beneficiaries enrolled in the Birth Center Model had lower rates of preterm birth, low infant birth weight, and Cesarean section compared to similar Medicaid programs not enrolled.[88] In addition to improved outcomes, the program also lowered care utilization and costs: compared to similar Medicaid beneficiaries not enrolled, costs from birth through the first year of life were $2,010 lower for Medicaid beneficiaries enrolled in the program. Some of the Alaska sites struggled with implementing the model amid challenges with staff turnover and lack of staff support.[89] However, the Mat-Su Birth Center found that peer counseling improved staff members' ability to identify patients in need of additional support as well as provide breastfeeding support. Program enrollees also had fewer infant emergency visits and hospitalizations. An independent evaluation concludes that the Birth Center Model is a promising approach that Medicaid programs should consider to improve outcomes and lower costs for their covered populations.[88]

Between 2005 and 2010, the ANTHC sponsored a series of pilots to test strategies to improve ***screening rates for colorectal cancer*** among the state's AI/AN population.[90] These pilots included the training of

mid-level providers (nurse practitioners, physician assistants) in flexible sigmoidoscopy screening, to limited success. This was followed by a shift (2007) to supporting clinics for colonoscopy screenings (reimbursed either through capitation or a flat day-rate model) and to multiple patient navigator approaches, including tracing patients' first-degree relatives (2007) to approach about screening and using navigators to guide patients through the screening process (2009-2010). Peer-reviewed findings note an increase in colorectal cancer screening rates over the time period, from 41 percent to 55 percent and conclude that the screening clinic model was the most effective strategy; however, findings about costs were not available.

Data Analytics

Ensuring that Alaskans have access to high-quality care while containing costs requires efficient and timely communication among providers and patients, as well as a robust capacity to analyze data (for example, on spending or outcomes) that can inform care delivery. With ready access to patient health information, providers and health care organizations can use data analytics to employ population health management strategies, measure quality as part of value-based payment models, improve care coordination, and ultimately achieve care that is centered on the patient, family, and community.

Reforms related to health IT and data analytics feature prominently in the AKHCCs' set of recommendations (2014). AKHCC's core strategies call for phased implementation of an All-Payer Claims Database as a chief means to coordinate data collection, analytics, and data sharing across multiple providers and delivery systems. In addition, expanded support for electronic health records, development of a state health information exchange (HIE), and reimbursement for telemedicine are identified as key foundations for data analytics (including data collection and sharing) that can move Alaska toward delivery system reform and quality improvement.

In this section, we consider data analytics not only in terms of the sharing and analysis of data through health information exchanges and EHRs but also in terms of telemedicine reforms. As appropriate, our review notes where such reforms might have implications for reform related to primary care and coordinated care.

Reform before 2008

For Alaska, telehealth services have been an important strategy to support care delivery across remote areas to a rural population and to leverage limited primary and specialty provider availability. In 1998, multiple federal agencies, including the IHS, the DHHS, the Department of Defense, and the Department of Veterans Affairs established the Alaska Federal Health Care Access Network (AFHCAN).[91] AFHCAN advanced telehealth in Alaska by creating and distributing telemedicine "carts"—"a combination of off-the-shelf hardware and specifically designed software, which utilized a web-based 'store-and-forward' interface and data collection protocol."[92] From 1999 to 2002, AFHCAN linked 235 federal and state sites into a telehealth network allowing CHAs and providers working in remote communities to connect with providers using video otoscope, digital camera, digital ECG, and telepsychiatry. These tools allowed CHAs to quickly seek guidance on providing patient care from physicians and also enabled physicians to deliver care directly to patients in remote locations. For example, since 2000, the Alaska Department of Corrections has used video conferencing to connect prisoners throughout the state with psychiatric support from Anchorage.[37] Anchorage-based psychiatrists delivered weekly voice visits to patients in correctional facilities in Seward, Fairbanks, Ketchikan, Juneau, Kenai, Bethel, Nome, and Kotzebue.

Gateway Mental Health Center in Ketchikan, Bartless Memorial Hospital, Alaska Psychiatric Institute, and Manilaq Medical Center also delivered telepsychiatry.[93] In 2002, the state Medicaid program began reimbursing for telehealth services.

Internet connectivity is a key precondition for telemedicine and for data sharing. Much of the Alaskan population, as well as health system anchor institutions, such as hospitals, schools, libraries, and municipal or borough governments, have struggled to obtain adequate access to broadband.[94] Advancements in connectivity across the state have set the stage for further development of Alaska's HIT infrastructure. In 2010 the U.S. Department of Agriculture's Rural Utilities Service awarded $88 million in federal funding to General Communication Inc. (GCI), a telecommunications corporation operating in Alaska, to extend terrestrial broadband service for the first time to Bristol Bay and the Yukon-Kuskokwim Delta, an area the size of North Dakota.[95] In 2011, GCI began the Alaska infrastructure project—the Terrestrial for Every Rural Region in Alaska (TERRA) network. The goal of this project was to provide high-speed terrestrial broadband access and 3G/4G mobile service to 84 rural communities. Through one of the largest microwave-fiber networks in the country, numerous regional health corporations, Alaska Native organizations, and other entities now have access to critical bandwidth, enabling high-speed data streaming and video-conferencing. By 2016, Quintillinon Subsea Operations in partnership with GCI and other Alaska infrastructure partners installed the first fiber optic cable in the Northwest Passage on the floor of the Bering and Chukchi seas, expanding internet and communication capabilities to the Arctic communities of Nome, Kotzebue, Point Hope, Wainwright, Barrow, and the North Slope.

Selected Reforms, 2008 to 2018

The past decade has seen an intense period of innovation around data analytics and HIT in Alaska. Exhibit 7 summarizes some of the highlights in this area.

Exhibit 7: Selected Reforms Related to Data Analytics, 2008 to 2018

Name	Leader of the Initiative	Entity Providing Funding	Status	Population(s)	Health Services
Statewide Reforms					
Alaska eHealth Network (HIE)	HealthConnect Alaska	AKDHSS	2010	Medicaid	Prevention; primary, secondary, and tertiary care
Cerner: Single Electronic Health Record - Tribal Project	ANTHC, SEARHC, ANMC, Kodiak Area Native Association, Copper River Native Association and Norton Sound Health Corporation	IHS	2010	AI/AN	Prevention; primary, secondary, and tertiary care
Tri-state Children's Health Improvement Consortium (T-CHIC)	AKDHSS	CMS	2010	Medicaid and CHIP enrollees (children)	Primary Care
EHR Incentive Program	AKDHSS	Medicaid	2011	Medicaid enrollees	Prevention; primary, secondary, and tertiary care

Name	Leader of the Initiative	Entity Providing Funding	Status	Population(s)	Health Services
Transforming Clinical Practice Initiative	**University of Washington; multi-sector partnership of providers, health care systems, and associations**	**CMS**	**2015-2019**	**All Alaska residents**	**Primary, secondary, and tertiary care**
SB 74: CCD project (real-time exchange of patient data across hospitals)	AKDHSS	AKDHSS	2016+	Medicaid enrollees	Primary care
Project ECHO	ANTHC	Multi-payer	ongoing	AI/AN residents across the state	Primary and secondary care
Reforms Based in Anchorage and/or Matanuska-Susitna Valley					
Livongo for Diabetes digital platform	Livongo	Premera	2017+	Members in Anchorage	Primary and secondary care
Million Hearts: Cardiovascular Disease Risk Reduction Model demonstration	Eastern Aleutian tribes	CMS, CDC	2017	Anchorage, Gulf Coast	Secondary and tertiary care
Other Regional and/or Local Reforms					
EHR Reminders	**Kodiak Area Native Association**	**IHS**	**2009-2011**	**Residents living in Kodiak (Southcentral)**	**Prevention**

NOTE: Reforms in bold are among the eleven that the PMC has prioritized for assessment.

Health Information Exchange [HIE]. In 2009, Senate Bill 133 (SB 133) called for the modernization of AK's health IT by developing a secure HIE to connect disparate EHR systems across the state.[37] After submitting a draft HIT plan to the Office of the National Coordinator (ONC) in 2009, DHSS entered into a cooperative agreement to develop an HIE in Alaska.[95] In 2010, DHSS contracted with HealthConnect Alaska (also known as Alaska eHealth Network AeHN) to develop and manage Alaska's HIE.[95] ***HealthConnect*** then contracted with Orion Health Inc. to implement the software for HIE. In 2013, pilot sites in Fairbanks launched Alaska's query-based HIE.[36] In 2016, the Medicaid Redesign Project recommended increasing HIE's capacity through linkages with hospitals and other providers and by integrating the Prescription Drug Monitoring Program database; in addition, a pilot was proposed to reduce ED costs by enabling sharing of patient information across multiple institutions (see description below, as part of Coordinated Care Demonstration).

Medicaid reform under SB74 included a requirement that AKDHSS develop a Health Information Infrastructure Plan. The draft plan identified multiple concerns articulated by stakeholders, from lack of interoperability, data governance guidance, or a list of providers using the system, to limited capabilities to support data analytics and telemedicine.[96, 97] The NORC team's meta-analysis report includes a more detailed assessment of findings regarding the HIE. A 2017 survey of providers across the state found that although access to internet and EHR usage was common, health information exchange among providers remained limited.[95] More recent data from the 2018 Update of the State Medicaid HIT Plan indicates that Alaska's HIE enables communication among 470 provider organizations and more than 3,000 health care providers, with patient information from over 40 EHRs.[95]

Electronic health records. In 2009, the American Recovery and Reinvestment Act gave major impetus to the development and use of EHRs, offering a 90 percent federal match to support state

planning activities.[98] Alaska received $900,000 toward this end and produced the State Medicaid HIT Plan (SMHP) and launched the ***EHR Incentive Program*** in 2011.[99] Federal incentives extended to Medicare, with CMS support for e-prescribing under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. Interoperability was an early concern, highlighted by findings from a 2010 survey of physicians and clinic managers across 29 communities by the Alaska EHR Alliance, funded by AKHCC.[37] The survey identified 55 different EHR systems and noted that one-third of the EHR systems were not connected to another entity, such as labs or pharmacies. Although Centricity (11 percent) and eClinicalWorkers (8 percent), were most commonly reported, there was no single platform comprising a significant portion of the AK EHR market.

Tribal health systems have led the way in implementing and sustaining a unified, interoperable approach to EHRs. One notable reform began in 2010 with ANMC's move from paper to an EHR developed by Cerner.[100] As part of this migration, ANMC implemented a computerized physician order entry to communicate and document patient care decisions. In 2016, the Southeast Alaska Regional Health Consortium (SEARHC) became the fourth regional partner to join ANTHC on their Cerner EHR.[101] The other partners in the Anchorage Service Unit are the Kodiak Area Native Association, Copper River Native Association and Norton Sound Health Corporation; other tribal partners included the Eastern Aleutian Tribes, Aleutian Pribilof Islands Association, Native Village of Eklutna, Chugachmiut, Kenaitze Indian Tribe, and Mt. Sanford Tribal Consortium. Once fully operational, this shared EHR is anticipated to capture two-thirds of outpatient encounters throughout the Alaska Tribal Health System, allowing providers across regional or community locations, as well as inpatient and specialty care settings, to easily access uniform, up-to-date records and data analytics to support clinical decision-making.

Telemedicine. As of 2009, AFHCAN consisted of 248 sites across the state, representing 44 beneficiary organizations, including Native and tribal groups, veteran and military providers, and the state of Alaska.[37] With the increase in internet connectivity across the state, AFHCAN expanded to using broadband video conferencing.[36] In 2012, it was estimated that telehealth eliminated the need for patient travel for 75 percent of specialty care visits and 25 percent of primary care visits.

Numerous organizations across Alaska have been delivering telehealth for years:

- The Alaska Psychiatric Institute (API) Tele-Behavioral Health Care Services program serves rural communities in south-central and northern Alaska via video-teleconferencing technology.[37]
- The Alaska Rural Telehealth Network (ARTN) operates in 11 communities across Alaska, including Soldotna, Cordova, Petersburg, Wrangell, Valdez, Kodiak, Seward, Sitka, Glennallen, Unalaska, and Homer. Sites included in this system have digital x-ray and mammography. The system uses a Picture Archive and Communications System (PACS) to allow sites to share these images with a radiologist.[37]
- Project ECHO, managed by the ANTHC Telehealth department, increases the capacity of primary care providers by enabling video consultations with a multidisciplinary specialty team.[102] For example, palliative care TeleECHO supports the delivery of Palliative Care specialty services to patients who might not otherwise have had access to them.[103]
- In 2009, the ANMC responded to approximately 3,000 telehealth cases, handling 66 percent of these consultations on a same-day basis and half of these cases in an hour or less. The growth of video conferencing appeared to be increasing the rate of these consultations three- or four-fold every 12-18 months.[37] As of 2013, telehealth connected 180 AN community village clinics, 25 subregional clinics, 4 multi-physician health centers, 6 regional hospitals, and the ANMC in Anchorage.[91]

Given the number of players in this space, the Alaska Collaborative for Telemedicine and Telehealth (AKCTT), a statewide interagency forum, serves as a convening organization for telehealth/telemedicine professionals in the state. In 2016, passage of SB 74 expanded the availability of telehealth services in Alaska by eliminating the requirement that providers practice in the state.[104] HB 234, also passed in 2016, required insurance plans to provide the same coverage for telemental services as in-person mental health visits without a need for prior in-person visits.[104] A Telemedicine Workgroup established under SB 74 convened 17 stakeholders to produce a set of recommendations to guide redesign of existing infrastructure.[105]

Data analytics to support care delivery. Over the past decade, a handful of demonstrations have tested the feasibility of data analytics to improve targeting of services delivery, greater access to specialty care, and improved patient chronic disease self-management.

Reforms have used predictive modeling to identify patients to target for screening. For example, the Eastern Aleutian Tribes began participating in the ***Million Hearts: Cardiovascular Disease Risk Reduction Model*** in 2017. This five-year demonstration supported by CMS aims to prevent heart attacks and strokes among Medicare beneficiaries aged 40-79 who have not had these conditions before.[106] Through the model, practitioners use predictive modeling to generate risk scores and develop mitigation plans for eligible FFS Medicare beneficiaries. The demonstration is a randomized control trial that includes 516 participating organizations; in the future, evaluation findings may be available.

Predictive modeling is also an element of the ***Transforming Clinical Practice Initiative*** (TCPI) that Alaska providers joined in 2015. This CMS-funded demonstration offers peer-based learning through Patient Transformation Networks (PTNs) that support 140,000 clinician practices nationally.[107] Patient Transformation Networks (PTNs) are a means to coach and mentor clinicians in improved quality of care and use of health data to identify care gaps and target services. Two organizations—the Community Health Center Association of Connecticut, Inc., and University of Washington—are implementing PTNs that include Alaska providers.[108] The Connecticut grantee has a focus on supporting clinicians working in health professions shortage areas where diabetes, asthma, and hypertension are prevalent.[109] University of Washington works with clinicians across five Western states on topics that include care coordination for medically complex patients, quality benchmarking, a telemedicine, and data-sharing. No evaluations have been identified to date, either for TCPI nationally or related to implementation of the program in Alaska.

A third example of this type of reform is the ***Tri-state Children's Health Improvement Consortium*** (T-CHIC), a child health care quality demonstration project funded by CMS through the Children's Health Insurance Reauthorization Act (CHIPRA) Quality Demonstration. The T-CHIC brought together the Medicaid/CHIP programs of Alaska, Oregon, and West Virginia. Oregon led this alliance, which was awarded $11.3 million for a five-year period (2010-2015).[110] T-CHIC worked specifically on quality reporting, developing enhanced HIT, and expanding care models such as PCMH.[111] Alaska supported three practice sites to implement a medical home model in rural and frontier settings, collect core children's quality measures, improve care coordination and HIT infrastructure, and connect providers to resources through the state's HIE. The Alaskan sites were successful in reporting out on 13 of the core measures in FY2011, earning an award at the CMS National Quality Conference in June 2012 for being one of only seven states that reported out on more than half of the core set of measures. In addition, the Alaskan sites focused on collecting quality data in EHRs, producing a data mall that presented measures by week, clinic, and provider, and facilitated analysis to support Southcentral's integrated care teams (Nuka system).

In addition, data analytics reforms have support patient self-management. During 2008, the Kodiak Area Native Association (KANA) ―a non-profit corporation providing health care and social services for AI/AN people in the Koniag region and six surrounding villages[i]―collaborated with IHS to implement the ***KANA Electronic Clinical Reminders*** pilot. This reform used an incremental process to test the usefulness of reminders for five key preventive screenings: tobacco use, alcohol use, depression, intimate partner violence, and a comprehensive cardiovascular exam. One study finds that between 2007 and 2011, screening rates for all five measures improved considerably, to levels that were significantly above the national average for IHS facilities.[112] This reform offers promise for replication and scaling across other regions in the state. The Livongo for Diabetes digital health package offers an example of commercial reform in this area. In 2017, Premera agreed to reimburse care delivered through Livongo for physicians located at Medical Park Family Care, in Anchorage. The package includes mHealth devices and an online care management platform that will provide patients with real-time round-the-clock access to support, and providers to access patients' health data in between visits.[113]

Payment Reform

The AKHCC made payment reform one of its key recommendations, for payment structures that would "incentivize quality, efficiency, [and] effectiveness" (2014). The third of the AKHCC's eight core strategies calls for payment reform that makes local approaches a priority (acknowledging the Nuka System's home-grown character), as well as primary care. In addition, the strategy emphasizes the need to consider consolidating state purchasing of health care and to align different types of purchasing (e.g., commercial, public, and federal) in a coherent and intentional multi-payer approach. In the past decade, Alaska has made inroads on these recommendations, with both systems-level change and a variety of experiments intended to test value-based purchasing (VBP).

Reform before 2008

The blended payment model represented by the Nuka System stands out in the pre-2008 landscape, where fee-for-service (FFS) reimbursement remains in many ways the norm for Alaska. Growing attention to value-based purchasing and payment reform accompanied passage of the ACA nationally in 2010, well into the time period reviewed in our scan.

Selected reforms, 2008 to 2018

In the past decade, there have been several significant state-wide payment reforms related to the Medicaid program, including the 2015 expansion under the ACA and the Healthy Alaska Medicaid Redesign initiative. They were followed in 2016 by the Alaska Reinsurance Program (HB 274), which was designed to address premiums in the state's health insurance exchange, the broad-based overhaul of the Medicaid program (SB 74), and consideration of a proposed Health Care Authority to consolidate state purchasing of health care, beginning in 2017. At the same time, distinct groups of stakeholders have tested, and are preparing plans to test, specific VBP models. Exhibit 8 summarizes reforms discussed in this section.

[i] KANA was founded in 1966 with the goal of improving health and wellbeing by providing medical, dental, behavioral health, and community service programs to serve the communities of Kodiak, Akhiok, Karluk, Old Harbor, Ousinkie, Port Lions, and Larsen Bay.

Exhibit 8: Selected Payment Reforms, 2008 to 2018

Name	Leader of the Initiative	Entity Providing Funding	Status	Population(s)	Health Services
Statewide Reforms					
Expansion of Medicaid under ACA	AKDHSS	CMS	2015+	Medicaid enrollees	Preventive, primary, secondary, and tertiary care
Healthy Alaska Medicaid Redesign	AKDHSS in partnership with AMHTA	AKDHSS	2015+	Medicaid enrollees	Primary, secondary, and tertiary care
HB374: Alaska Reinsurance Program; and Section 1332 waiver	AK Dept. Commerce, Community, and Econ. Development, Div. of Insurance	CMS, AKDHSS	2016+	State residents purchasing individual health coverage from Alaska marketplace	Preventive, primary, secondary, and tertiary care
SB74: Health Care Authority Feasibility Study	AKDHSS	AKDHSS	2018	Medicaid enrollees, state and local employees, state and local retirees	Preventive, primary, secondary, and tertiary care
SB74: using APM for pharmacy	AKDHSS, Oregon Health Sciences University's Center for Evidence-Based Policy	Arnold Foundation grant	2017	Medicaid enrollees	Pharmacy
Reforms Based in Anchorage and/or Matanuska-Susitna Valley					
Bundled Payments for Care Improvement: Models 2 and 3	**Alaska Hospitalist Group/ Providence Alaska Medical Center**	**CMS**	**2014+**	**Medicare beneficiaries in Anchorage**	**Primary, secondary, and tertiary care**
Bundled Payments for Care Improvement, Advanced Model	Alaska Hospitalist Group/ Providence Alaska Medical Center	CMS	2018-2023	Medicare beneficiaries in Anchorage	Preventive and behavioral health
SB 74: CCD, pilot of Medicaid managed care model	United HealthCare	AKDHSS	2016+	Medicaid enrollees in Anchorage	Primary, secondary, and tertiary care
SB 74: CCD, Alaska Innovative Medicine (AIM), pilot of bundled payments	Alaska Hospitalist Group	AKDHSS		Premera and Medicare in Anchorage	Primary, secondary, and tertiary care
SB 74: CCD, pilot of PCMH model	Providence Family Medical Center	AKDHSS	2016+	Medicaid enrollees in Anchorage	Primary care

NOTE: Reforms in bold are among the eleven that the PMC has prioritized for assessment.

State-wide payment reform tied to delivery system reform. Before Medicaid expansion under the ACA, Alaska's Medicaid Redesign and Expansion Project assessed options for reducing costs and improving quality. Based on an environmental scan of reforms nationally and input from a broad array of stakeholders, this project made recommendations for five initiatives, to improve primary care, access to behavioral health, and emergency care, to build a supporting data analytics and information technology

infrastructure and to pilot VBP models that might be replicable across the state by 2021. One proposed model for testing was a Health Home, for which primary care providers would receive a monthly case management fee as well as FFS reimbursement; while a Health Homes model has not been implemented to date, a subsequent Medicaid reform to address over-utilization of EDs has tested a primary care case management system. A second proposal was for AKDHSS to contract with third-party Administrative Services Organization (ASOs) to manage reforms. The proposed emergency care initiative would feature shared savings and IT infrastructure improvements to lower ED over-utilization. Finally, the project advised AKDHSS to collaborate with provider groups to form accountable care organizations (ACOs) in three regions, using a shared savings/shared losses payment approach that offered less risk than full capitation or global budgeting.

Expansion of the Medicaid program in 2015 under Governor Bill Walker marked a major step in state reform. As a result, 44,000 Alaskans have enrolled in Medicaid[114] and the uninsured rate decreased by almost 5 percent from 2013 to 2017.[115] The federal government has invested approximately $1 billion in the state's health care industry and has paid for 100 percent of the expansion costs through 2016.[116] In 2017, the state began to pay 5 percent of the cost and in 2018 the state began to pay 6 percent of the cost; the state is required to increase payments to 10 percent by 2020 and remain at that spending level.[117]

Multiple state-level reforms were launched around the time of Medicaid expansion. In 2016, projections that individual market premium would increase by 42 percent prompted passage of **House Bill 374,** which put in place a reinsurance system administered by the Alaska Comprehensive Insurance Association. To counteract rising premiums, this system reimburses insurers for the ongoing medical costs of enrollees with high-cost conditions, with no effect on the enrollee in terms of premium or access to care. Alaska's tax on health insurance helped generate $55 million that funded the reinsurance program in 2017,[118] decreasing premiums from 42 percent to 7 percent and keeping Premera, the sole remaining insurer, in the individual market.[119] More recently (2018), the state was successful in receiving a section 1332 waiver that will subsidize the individual marketplace, on the basis of savings attributable to the reinsurance fund.[120] It is expected that 1,460 individuals will gain coverage as a result of the program and that the state will receive $322.7 million in federal funds over a period of five years for the program. For 2018, the program will cost an estimated $59 million, of which CMS will cover $48.4 million.[121]

The same year (2016), the state enacted broad-ranging Medicaid reform under **Senate Bill 74 (SB74)**, a reform discussed in greater detail in our meta-analysis report.[122] Multiple provisions concern VBP and alternate payment models (APMs), including expansion of an earlier program to assess penalties on hospitals for avoidable readmissions and testing of bundled payments for specific episodes of care and global payments. AKDHSS is developing a group of Coordinated Care Demonstrations Projects, including two reforms located in Anchorage: a Medicaid managed care model to be implemented by United Healthcare (capitated per member per month payment, also including the Mat-Su Valley region) and a PCMH model (provider-based reform) to be implemented by Providence Family Medical Center.[123] Another example of SB74's focus on APMs is that being carried out by the Oregon Health & Science University's Center for Evidence-Based Policy, to identify how Alaska's Medicaid Pharmacy Program could address the impact of high-cost specialty medications and, through work with the Alaska Medicaid Drug Utilization review committee and providers, develop and implement new standards of care.[48] As these demonstrations are in their early stages, no evaluation findings have been identified to date by our team.

In addition, SB 74 required the Alaska Department of Administration (AKDOA) to study the feasibility of creating a state health care authority (HCA) to consolidate purchasing for a diverse group of residents (e.g., Medicaid enrollees, state and local employees, state and local retirees).[124] To date, four reports have been produced, to assess publicly funded health care plans and identify potential areas for cost-savings,[125] describe structural and governance considerations for a proposed HCA,[126] present recommendations about potential governance models for the HCA based on other states' experiences,[127] and analyze prospects for cost savings through consolidating Alaska's public employer health plan administration and procurement.[128] More detail about these reports is provided in the meta-analysis report that accompanies this history scan; an assessment of findings from the HCA feasibility work is out of scope for the NORC team.

VBP: bundled payment models. Starting in 2013, the Alaska Hospitalist Group in Anchorage has participated in CMMI's national ***Bundled Payments for Care Improvement (BPCI)*** initiative, to test whether Medicare expenditures can be decreased without compromising quality by linking payments for all providers during an episode of care.[129] This linkage, or "bundling," is a strategy to improve care coordination by aligning incentives among providers across specialties and care settings. The specific innovations being fielded (Models 2 and Model 3) involve a retrospective bundled payment arrangement in which actual expenditures are reconciled against a target price for an episode of care. In Model 2, the episode includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge. In Model 3, the episode begins with the initiation of post-acute services with a skilled nursing facility (SNF), inpatient rehabilitation facility, long-term care hospital, or home health agency. For each grantee, testing involves two phases—a "preparation" period and "risk bearing period."[129] As of 2015, all awardees had entered the second phase, which was intended to last for three years; some awardees were given extensions for up to two additional years. An independent evaluation of the first three years for all grantees finds that the model successfully reduced Medicare FFS expenditures, although the demonstration ultimately resulted in net losses for Medicare, since the reconciliation amounts paid to awardees were greater than savings accrued through decreased FFS payments.[130] There were improvements in quality of care for beneficiaries who participated in Model 2 (bundling for hospital care): fewer were discharged to institutional settings following acute-care stays and those who stayed in a skilled nursing facility (SNF) had shorter lengths of stay. In general, the model's success in reducing FFS payments while maintaining quality of care levels show that is a promising episode-based payment model, although specific evaluation findings for Alaska were not available for review. The Providence Alaska Medical Center in Anchorage recently began participating in the ***BPCI Advanced Model***, which builds on the previous BPCI by testing a new iteration of bundled payments for 32 clinical episodes, related to mental health and substance abuse disorders.[131]

Defining Bundled Payments
A bundled payment is reimbursement at a set price for multiple healthcare services, typically those previously reimbursed separately. Bundling may have one or more goals, including more efficient care delivery, greater coordination across providers, higher quality of care, and/or greater transparency about the cost of care. Risk adjustment of pricing is often done when multiple services are bundled and/or larger or more diverse populations are enrolled. Bundles may be partial if they do not include all services connected to an episode of care; alternatively, a bundle may span multiple episodes. Bundled payments may resemble fee-for-service (FFS) reimbursement, for example, a set or global fee for a given episode. Source: Center for Healthcare Quality & Payment Reform, The Payment Reform Glossary (n.d.)

In addition, primary care physicians in Anchorage and the Alaska Hospitalist Group are testing a bundled payment approach under the ***Alaska Innovative Medicine (AIM)*** model, a physician-led reform that is a

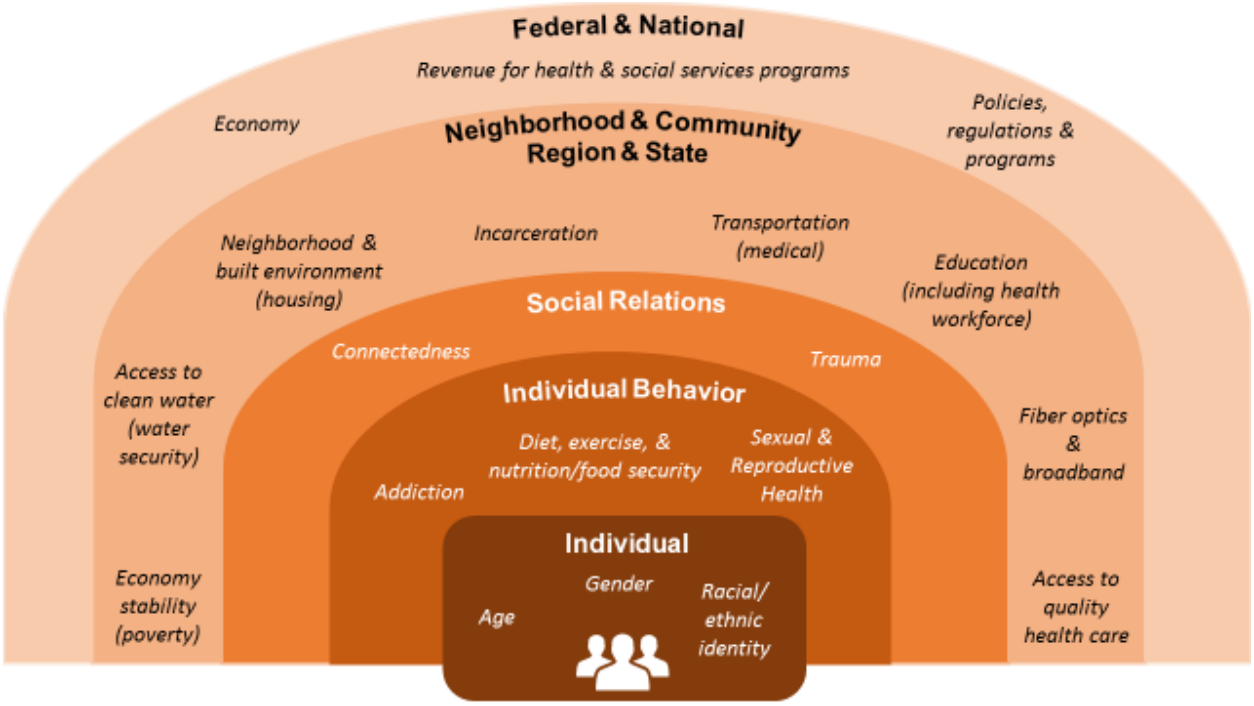
part of the Medicaid Coordinated Care Demonstration program.[132] The model uses social workers and case managers to problem-solve and communicate with a team of doctors, the insurer, and the patient.[133] The founders realized the need for waste reduction and improvement of health care delivery, and sought to improve health care while also allowing physicians to maintain their practices.[134]

Social Determinants of Health

A unique set of geographic, climatic, economic, and cultural factors distinguish Alaska from other places; as a result Alaskans experience unique health challenges and influences. According to the World Health Organization (WHO), "Social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[135] These non-medical influences on the health of Alaska's populations can have significant implications for the needs for health services, the extent to which these needs are fully and appropriately addressed, and the ways in which health reform can minimize or eliminate health inequities that have their roots in demographic, socio-economic, and geographic differences among state residents.

For the purposes of this report, a starting point for defining SDOH is to consider those social and physical influences associated with the leading causes of mortality and morbidity in Alaska including: addiction; diet, nutrition, and exercise; social connectedness; environmental exposures; access to clean water; and sexual and reproductive health (Driscoll, 2013). In addition, notes from PMC meetings (spring of 2018) offered an additional list of SDOH. Exhibit 9 depicts a tailored version of a commonly used visual for SDOH in Alaska that illustrates the myriad of factors that influence the health of Alaskans, ranging from those most closely tied to an individual (e.g., age, gender, heredity, epigenetics) to individual behavior and social relationships (e.g., family, tribal), to community and regional influencers (e.g., education, employment opportunities, the physical environment), and determinants linked to the federal policies and funding that support much of Alaska's infrastructure and programs. See the meta-analysis report that accompanies this report for a more in-depth discussion of SDOH in Alaska.

Exhibit 9: Social Determinants of Health in Alaska



Source: Based on Dahlgren and Whitehead.[136]

In this section, we review selected health reforms identified as addressing one or more SDOH. Reforms related to access to quality health care are addressed for the most part in the primary care utilization/coordinated care section above. In addition, this section considers a small number of reforms that address population health rather than acute medical care.

Selected reforms before 2008

Social Relations

Domestic violence and abuse. Two innovative programs developed under the auspices the Southcentral Foundation are designed to address the needs for social supports and health education for individuals and communities facing the consequences of domestic violence; child abuse, neglect, and related trauma; and comorbidities of substance abuse and mental illness. The Family Wellness Warriors Initiative offers training (Beauty for Ashes, learning circles) throughout the state, based at locations in Anchorage and the Matanuska-Susitna Valley.[137–139] The Alaska Women's Recovery Project dates to the early 2000s and offers peer-facilitated engagement for communities, with funders including the Alaska Mental Health Trust Authority.[140]

Neighborhood and Community, Region and State-Level Influences

Access to clean water. As noted earlier in this report, sanitation has been a longstanding and challenging issue for Alaska residents. A retrospective assessment of rural innovations (1970 to 2005) described the difficulties faced by rural communities reliant on hauled water and at risk for the spread of communicable diseases due to shared washing facilities and unsanitary disposal of waste.[141] A recent

estimate puts the number of households without water service or sewage at approximately 3,300.[142] ANTHC has had a long-term commitment to installing water systems and addressing sewage needs in rural villages, through its Division of Environmental Engineering and the National Tribal Water Center (tribalwater.org).

Health workforce. Alaska's longstanding shortages of health care providers represents a barrier to access, one that exacerbates disparities in care and outcomes. For this reason, training programs aimed at alleviating these shortages are considered relevant to addressing SDOH. ANTHC has played a key role in bolstering the nonclinical workforce by training community members to deliver care. In the 1950s, volunteers serving as chemotherapy aides provided direct observed therapy for tuberculosis,[143] which led to a dramatic reduction in incidence of the disease that had devastated AN communities.[144] In the 1960s, the integration of formal training led to the development of the Community Health Aide Program (CHAP), which was officially launched by the ANTHC and funded by Congress in 1968.[145] The CHAP model addressed a number of health care access issues, including geography challenges, villages being too small to support midlevel providers or physicians, harsh weather conditions, high transportation costs, and difficulty recruiting and retaining trained health care providers.[145]

Systems for trainings and credentialing have been key for building the capacity of the community health workforce. In 1998, the Alaska area director appointed a CHAP Certification Board that still operates, overseeing a tiered training program through which individuals selected by their communities can obtain progressive levels of training and certification.[146] In 2002, CHAP standards were expanded to include dental health aides (DHAs) and therapists (DHTs),[143] who began practicing 2006.[32,147] Similar to CHAs, there is a tiered training program available for DHAs through which prospective trainees nominated by their communities can pursue progressive levels of training that enable them to widen the scope of their practice.

In addition, physician training through the Target Rural Underserved Track Program (TRUST) continues to be seen as an important, ongoing part of efforts to build capacity for primary care. Jointly sponsored by five western states with sizable rural populations (Washington, Wyoming, Alaska, Montana, and Idaho), the program dates to the 1970s and features postgraduate training shared between the University of Washington School of Medicine and participating state universities.[148] TRUST is designed to recruit future physicians and physician assistants from rural communities, tailor medical training to address rural health concerns, facilitate long-term relationships between medical students and communities, and steer graduates into residencies that meet rural needs.[149,150]

Selected reforms, 2008 to 2018

Of the 11 reforms that the PMC notes as priorities for this report, one (the Prince of Wales Health Network) (POWHN) represents the topic of reform addressing one or more social determinants of health (SDOH). However, there have been a number of relevant reforms in the past decade that offer important context for POWHN; these are listed in Exhibit 10 below and discussed briefly in the section that follows.

Exhibit 10: Selected Reforms Related to Social Determinants of Health, 2008 to 2018

Name	Leader of Initiative	Funding Entity	Status	Population(s)	Health Services
Statewide Reform					
Dental Aides	ANTHC	IHS, multi-payer	2006+	Community/ village members	Preventive, Primary
Behavioral Health Aides	ANTHC	IHS, multi-payer	2008+	Community/ village members	Preventive, Primary
Alaska Health Workforce Coalition	UAA	HRSA, state partners	2009+	All residents	Preventive, Primary, Secondary
Alaska Water and Sewer Challenge	AK Dept. Environmental Conservation	State	2013+	Rural residents	Preventive
Medicaid IAP State Medicaid-Housing Agency Partnerships Implementation Track Program	CMS	CMS	2017-2018	Medicaid enrollees	Prevention
AK Opioid Task Force	AKDHSS	AHDHSS	2016	All residents	Prevention
6/18 Initiative		CDC	2017+	All residents	Prevention
Smokefree Alaska law			2018+	All residents	Prevention
Reforms Based In Anchorage and/or Matanuska-Susitna Valley					
Housing First	Municipalities of Anchorage and Fairbanks	Alaska Housing Finance Corp., AMHTA	2011-2014	Homeless residents of the two cities	Prevention
Mat-Su Borough Crisis Intervention Team (CIT) Coalition	LINKS/ADRC	Mat-Su Foundation	2015+	Residents of Mat-Su Borough	Prevention, Primary Care, Behavioral Health
Other Regional and/or Local Reforms					
Prince of Wales Health Network	**Regional and local providers and community groups**	**FORHP, AK Community Foundation**	**2007+**	**Residents, Prince of Wales Island**	**Prevention**

NOTE: Reforms in bold are among the eleven that the PMC has prioritized for assessment.

Reforms Related to Individual Behavior

Addiction. Recent efforts to address SDOH have centered on addressing the misuse of opioids. In 2016, AKDHHS launched the ***Alaska Opioid Task Force*** (AOTF) with the goal of developing recommendations to the governor and legislature on how to address this crisis. Some of the areas the task force seeks to address include law enforcement efforts to curb the importation of heroin into the state, prescribing practices related to pain management and opioid medications; understanding insurance and Medicaid roles in preventing and managing opioid addiction; providing access to detox services; and studying prescription opioid drug misuse, diversion and abuse, among many others.[151] In 2017, the 6|18 Initiative began in Alaska with an emphasis on tobacco prevention and cessation, diabetes prevention via access to the National Diabetes Prevention Program, and hypertension management via medication management and teach-based care approaches.[152] The ***Smokefree Alaska Bill***, signed into law in July 2018, also addressed tobacco cessation and prevention. The law prohibits smoking in enclosed public

spaces as well as at worksites, and is expected to improve population health by reducing exposure to secondhand smoke.[153]

Diet, nutrition, and exercise. The ***Prince of Whales Health Network*** (POWHN) began in 2007 with the purpose of forging collaboration among disparate organizations serving the island's 4,200 residents (most of whom are Tlingit) living on the 2,500 square mile island. It represents a partnership among a diverse group of local stakeholders, including the Southeast Alaska Regional Health Consortium, Alicia Roberts Medical Center, state of Alaska Craig Public Health Center, Community Connection, Alaska Island Community Services (AICS), PeaceHealth Medical Group Prince of Wales, Whale Tail Pharmacy, and Southeast Dental Center. Because the island has no commercial airline, residents are largely unable to travel to the mainland for care. POWHN has been successful in creating a collaborative network focused on a range of public health initiatives, including increasing access to and awareness of healthy foods and offering suicide prevention training.[154] While descriptions of POWHN emphasize the network's role in bolstering health infrastructure and health IT to improve communications and data-sharing, priorities also include youth leadership, supporting elder and adult care needs, addressing adverse childhood experiences, and opioids. Funding has come from federal grants (Office of Rural Health Policy) and state (a four-year $900,000 behavioral health grant), as well as annual giving required of member organizations through the Alaska Community Foundation. No evaluation has been identified to date.

Reforms Related to Neighborhood, Community, Region, and State SDOH

Access to Clean Water. The Alaska Department of Environmental Conservation (AKDEC) launched the Alaska Water and Sewage Challenge in 2013, to spur the design and testing of new models for rural villages without centralized water and sewer service.[142] Six teams have won funding, each a partnership between a rural Alaska community and outside technical experts, to develop, field, and evaluate innovative approaches to improve water security.[155]

Housing Security. In 2009, the Alaska Council on the Homeless published a 10-year plan to confront growing rates of homelessness in Alaska.[156] Among other strategies, the report called for efforts geared toward the chronically homeless, particularly those with frequent touches with emergency care services and the criminal justice system. Alaska's ***Housing First Program*** began in 2011 as a three-year evaluation to assess the costs associated with this supportive housing approach.[157] In Anchorage, the Rural Alaska Community Action Program opened a converted hotel with 46 units. In Fairbanks, Tanana Chiefs Conference opened another site with similar capacity.[158] The evaluation found that after tenants moved into Housing First facilities, emergency service usage decreased, use of outpatient services increased, medication adherence improved, and alcohol usage declined. However, the group continued to incur high costs for health care.[159] In addition, the state was awarded technical assistance funding for planning purposes, as part of its participation in the federal Medicaid Innovation Accelerator Program (IAP) State Medicaid-Housing Agency Partnership Track; the resulting plan, to offer permanent supportive housing for 250 people, was submitted in 2018.[48]

Incarceration. In 2015, the Mat-Su Health Foundation began funding annual mental health first aid training for first responders through the ***Mat-Su Borough Crisis Intervention Team Coalition***.[160,161] Objectives of the training are to help police offers and others de-escalate responses to persons experiencing a mental health crisis and improve access to behavioral health services. Modeled on a program developed by the Anchorage Police Department in 2001, the CIT has been credited with fostering collaborative partnerships across criminal justice and health care and is supported by the Alaska Mental Health Trust Authority and the National Alliance on Mental Illness.

Education. Between 2008 and 2009 the CHAP model was expanded to include ***behavioral health aides*** (BHAs) and practitioners (BHPs).[143] BHAs and BHPs must be trained first as CHAs and can pursue additional training to receive progressive levels of BHA certification, enabling them to provide screening, case management, community education (at lower levels of certification) and rehabilitative services for individuals with complex, co-occurring disorders (at high levels of certification), BHPs can provide team leadership and mentorship to BHAs with lower levels of certification. To further grow the community health workforce, ANTHC partnered with Ilisagvik College in August 2017 to offer a two-year training program through which individuals can earn an associate's degree and BHA certification from the Alaska Tribal Health System's CHA Program Certification Board. The program seeks to serve as a pipeline for the community health workforce by encouraging BHAs to pursue higher level degrees, enabling them to take on supervisory positions within the BHA program. Alaska also implemented the Dental Health Aide Therapist program in 2009, through which tribal communities can recruit Alaska to become dental therapists for the community and provide culturally competent preventive, and basic dental care.[32]

CHAP with its behavioral and dental components, has been key in not only addressing workforce shortage issues but also fostering a workforce that is attuned to local needs and able to address care in a culturally competent way, while raising awareness about key health issues among communities. The success of these programs is demonstrated by their reach. There are currently about 550 CHA/Ps working to serve 170 rural villages in Alaska.[58] On average, each DHAT team provides care for 830 patients during 1,200 patient encounters a year; approximately 700 are preventative and 500 are restorative. As a result of this program, 40,000 individuals in rural Alaska now have direct access to care.[162] It is estimated that 19 DHATs generate 76 jobs, of which half are in rural Alaska and produce $9 million in economic activity.[162]

Considering workforce issues more broadly, the ***Alaska Health Care Coalition*** has become a statewide, multi-sector planning and convening body with a focus on the full range of health-related occupations.[163] The Coalition has developed innovative reforms including the use of the federally-registered apprenticeships program, together with funds from the State Training and Employment Program, to train and place a range of new staff; develop curricular standards and assessment tools in partnership with Alaska Area Health Education Centers; promote state loan repayment programs for health providers; and coordinate planning with the state Medicaid program around future needs in connection with payment and delivery system reform.

Chapter Summary

Set against the broader context of health reforms across the five topic areas of interest, our assessment of the eleven health reforms identified as priorities by the PMC showcases a wealth of details but few analytic findings based on formal program evaluations or peer-reviewed publications. Considering related reforms enriches our understanding of each priority reform, enabling an assessment of trends that is presented in the following chapter.

Chapter Six: Lessons from Alaska's Recent Health History

This chapter presents a synthesis of key findings and themes across the reforms reviewed as part of this scan. It then offers a set of observations about prospects for health reform in the state, based on lessons from the past decade. These observations relate to possible pathways forward for payment reform, programmatic changes, and delivery system reform. They are coordinated with the findings and themes put forward in the meta-analysis report that accompanies this historical scan. These pathways are sketched in outline, to be considered as part of the NORC team's analyses for the national scan and cost driver reports.

Findings across the Five Topics of Interest

Structural and Governance Considerations

Primary care and coordinated care. The Nuka system of care illustrates the value of multi-payer arrangements to support an integrated care model. Adequate organizational capacity is needed to integrate care delivery (including supporting data analytics) across providers and settings.

Data analytics. Alaska's Tribal Health System has been a leader in the use of EHRs, interoperability, and telemedicine. The Alaska Collaborative for Telemedicine and Telehealth (AKCTT), a statewide interagency forum, serves as a convening organization for telehealth/telemedicine professionals in the state. AFHCAN has and continues to play a major role in expanding telehealth capabilities across the state. IHS has been the primary funder of AFHCAN.[91] Another consideration is that the Federal Communications Commissions' Universal Services Fund subsidized the cost of a satellite T1 link; without this subsidy, rural sites might not be able to connect.[91]

Payment reform. Payment reform has taken place for the most part at the state level and closely is bound to Medicaid and administered by AKDHSS. Federal dollars and influence give overall shape to initiatives at the state and local level: through Medicaid, financial support to the Alaska Native and tribal health systems, and in smaller-scale experiments for Medicare beneficiaries. Anticipated consolidation of state purchasing through a proposed HCA will likely provide a framework that is leveraged by other payers and systems, given the overlap between Medicaid and other payers such as the IHS and the Veterans Administration. Southcentral Foundation has demonstrated leadership in value-based purchasing through the ACO-type model embedded in the Nuka System of Care recognized by the Healthy Alaska Medicaid Redesign.

Social determinants of health. Reforms to address SDOH have been devised by entities as small as an individual village and as large as a state agency or tribal organization with state-wide reach. Most of the reforms featured in this report are governed by multi-stakeholder partnerships (e.g., POWHN is jointly led by SEARHC, health providers, community-based organizations, and local businesses), even if funding comes from only one or two sources or a single federal award. At the state level, AKDHSS or AMHTA oversee many of the reforms. Reflecting the broad, non-medical scope of SDOH, key reforms are also overseen by organizations not typically involved in health planning, for example, the Alaska Housing Finance Corporation (Housing First) are overseen by AKDHSS or AMHTA.

Key Stakeholders

Primary care and coordinated care. Both federal and state government play important leadership roles, the former for Medicare beneficiaries and in grants for one-time, local demonstrations, and the latter for Medicaid beneficiaries and more systematic reforms that are statewide. In addition, the tribal health organizations are important stakeholders, and in particular Southcentral Foundation. Further, provider associations are actively involved in developing PCMH models that can achieve certification.

Data analytics. There are a broad number of stakeholders that have been engaged in efforts to expand and optimize data analytics capabilities in AK. These include healthcare facilities, provider practices, medical associations, tribal entities, mental health practices, the statewide Health Information Exchange (HIE), and AKDHSS. SB 74 called for the development of the Health Information Infrastructure Plan and the formation of a Telemedicine Workgroup; both efforts have made strides in engaging a broad array of stakeholders across sectors.

Payment reform. With payment reform a central driver of health reform overall in Alaska, a broad range of stakeholders have been actively involved in changes to the Medicaid program, with the state legislature, state agencies, and Alaska Native and tribal organizations featured prominently. Providers and commercial payers have also been represented in Medicaid reform.

Social determinants of health. As with other aspects of health reform in Alaska, the ANTHC plays a major role in developing, fielding, and supporting innovative approaches to addressing SDOH. State agencies comprise a second group of key stakeholders that particularly requires collaboration from community, medical, and social service agencies. These connections have been forged though the following initiatives: Alaska211, POWHN and AMCCI. Similarly, community members have been essential in the stakeholder process. Community members are actively involved in the CHA, DHA, and BHA programs. These programs is bolster the health care workforce while also ensuring access to culturally competent care.

Gaps

Primary care and coordinated care. Reforms focused on primary care and care coordination were clustered in the southern part of the state, seat of much of the state's population. While state-level planning is underway to test PCMH more broadly, and federal funds have been tapped to test PCMH, much of the innovation is happening either at Southcentral Foundation or locally.

Data analytics. AK's Health Information Infrastructure Plan identified noted that EHR systems have been inconsistently adopted across the state and that, despite improvements, there is still a lack interoperability. Workgroups engaged as part of the plan also identified lack of data governance policies and limitations on data analytics capabilities, HealthConnect capabilities, and use of telehealth as major gaps.[97] There have been limited or no efforts specific to areas outside Anchorage/Mat-Su Valley.

Payment reform. Experiments have been either statewide (related to Medicaid) or demonstrations based in Anchorage and the adjacent Mat-Su Valley (BPCI, SB 74 CCD), with the Nuka System of Care implemented in Anchorage, the Mat-Su Valley, and the Rural Anchorage Service Unit. Given the limits of our current historical scan, we have not identified substantive payment reform experiments in other regions of the state.

Gaps. The small number of reforms selected by the PMC for review in this report may not be representative of the experiments documented in the almost 300 publications about SDOH identified by ICHS in our initial historical scan list. Among those reforms described in this report, there are few that address SDOH related to poverty, the natural environment and climate change, transportation, access to broadband internet, unintentional injury (including occupational health and safety), or SDOH related to gender.

Strengths and/or barriers

Primary care and coordinated care. Alaska's longstanding commitment to improving access to primary care, together with substantial investments over the years in telehealth, represent strengths to be leveraged in designing and fielding health experiments related to primary care and coordinated care. In addition, a tradition of stakeholder engagement within tribal health organizations is an important strength that has generated some of the most innovative reform initiatives. Lack of adequate funds to sustain reforms in the long term remains a barrier, given the difficulty of achieving cost-neutrality or of attaining a positive return on investment.

Data analytics. AK has evolved with regards to its connectivity and capacity for EHR. While these efforts have set the stage for data analytics, few reforms/efforts have tested or substantially utilized data analytics as a means of improving population health.

Payment reform. One core strength for Alaskans is broad acknowledgement that the state's high cost of health care, and the relatively high rate of increase in costs in recent years is not sustainable and can be addressed. Political consensus around this concern has energized stakeholders across the state and motivated commitment to payment reform, particularly for the Bundled PCI Model 2 tested in Anchorage. AK could look at how to replicate this promising model in other similar settings. However, a significant barrier to payment reforms is the relatively low volume of patients in many areas. Multi-payer reform will be essential for having adequate volume to achieve savings (e.g., there are not enough Medicaid enrollees in some setting to achieve savings under bundles for episode of care).

Social determinants of health. Alaska's long experience with health workforce training program and the use of mid-level providers and others to deliver care in rural areas constitutes a strength, both to address limited economic opportunities and to improve access to quality health care.

Replicability and/or scalability

Primary care and coordinated care. While the Nuka System of Care has served as a model for reforming primary care and coordinated care in other parts of the United States and internationally, it faces significant challenges to replication or scaling within the state of Alaska itself. The fundamental building block for Nuka is the relationship of customer-owners to the health services organizations operated on their behalf; this dynamic may also characterize other tribal health organizations in the state but is distinct from the relationship of Alaska residents more generally to the health coverage programs (e.g., Medicare, Medicaid, employer insurance, benefits under the AMHTA, TriCare, VA benefits) that tie them to health services delivery systems, whether public or private. Another key to Nuka's success is the capability to align or blend multiple payment sources to cover costs connected with a PCMH model, for example, using IHS dollars to fill in where Medicaid or Veterans' benefits do not support care coordination. It remains to be seen whether the multiple PCMH pilots being fielded will succeed in aligning the dollars needed to sustain delivery system reform. A third challenge to replicating or scaling a

PCMH relates to the small volume of patients who can be empaneled locally in most of Alaska, given the small sizes of rural villages and great distances; what works in Anchorage or the neighboring Mat-Su Valley may not offer a positive return-on-investment in other regions of the state.

Data analytics. ANTHC's collaboration with SEARHC and other tribal health partners to develop a joint Cerner EHR system has the potential to serve as the basis for major data analytics/population health management efforts.

Payment reforms. Notable state-wide reforms, such as the section 1332 waiver to finance reinsurance of Alaska's individual marketplace and expansion of Medicaid under the ACA, are scaled by design. Demonstrations of bundled payments show promise, as do per-beneficiary-per-month partial capitation for patient-centered medical home approaches, given adequate patient volume or panel size; this may restrict such value-based purchasing reforms to larger health plans and more densely populated areas of the state. Replication or scaling of multi-payer successes such as the Nuka system of care have not yet proven themselves to be feasible.

Social determinants of health. High suicide rates is a pressing problem in Alaska. Efforts to address behavioral health problems, reduce the stigma around mental health and address social isolation are therefore critical. The BHA program shows promise for addressing this critical issue. An evaluation of the BHA, CHA, and DHA programs could demonstrate their impacts on health outcomes and indicate how the programs could be further expanded to serve Alaska villages that have limited access to care. On the other hand, another initiative that could be replicated or scaled is the POWHN. It was successful at building collaboration and this approach could potentially be replicated across other regions with limited access to healthcare services.

Findings: Commonalities

Health reform experiments in the state operate within a shared environment where costs continue to be high, the health care workforce remains in short supply, and remote geography challenges the ability to communicate and coordinate across providers and settings.

High and Increasing Health Care Costs. A Kaiser Family Foundation study found that Alaska's spending per capita was $11,064 in 2014.[164] The total spending for health care in Alaska reached $7.5 billion in 2010, which represented a 40 percent increase from 2005. The state also has commercial reimbursement rates that are much higher than other states. One recent study (2018) finds that the average reimbursement rate (percent of Medicare) of Alaska was much higher (273 percent) compared to similar geographic regions (157 percent in Idaho, 158 percent in Montana, 191 percent in North Dakota, and 147 percent in Seattle).[165]

Geography. Alaska's vast geographical landscape poses many challenges for the provision of healthcare not only because of the distances, but also because of the high cost of transportation.[166] Roughly two-thirds of the population lives in the area known as the Railbelt, stretching between Seward and Fairbanks. However the remaining third of the state's community lives in more rural regions.[167] A challenge faced by Alaskan residents living in remote areas is the large distance that exists between acute care facilities and communities. This distance coupled with the harsh weather conditions can prevent patients who experience severe illness or injury from obtaining immediate transport to acute care facilities.[36] The geographic challenge not only affects patient access to healthcare, but also impacts the relationship

between providers and CHAs. As mentioned in the *Social Determinants of Health* section, CHAs, behavioral health aides, and dental health aides are essential components of the tribal system.[93] They are the necessary link in connecting patients with proper services. Many physicians and dentists live in the Southcentral and Southeast passage regions, and are unable to provide in-person patient care. These long distances pose a challenge in the daily communication between physicians and dentists needed for patient care. Even though Alaska has been a pioneer in telemedicine, with some 248 sites connected to the Alaska Federal Health Care Access Network (AFHCAN) that links village clinics to regional hospitals and regional hospitals to ANMC, a lack of bandwidth and connectivity in many regions still hinder efficient collaboration.[94]

Health workforce shortages. The state faces ubiquitous health care provider shortages especially in rural areas.[168] Most regions of the state have been designated as a Health Professional Shortage Areas (HPSAs) based on the lack of primary care physicians, psychiatrists, and dentists. These regions cover 96 percent of Alaska's landmass and 39 percent of the state's population.[168] This challenge becomes more complicated when coupled with the state's health care industry's fast growing health care employment needs (45 percent) compared to the rest of the United States (19 percent).[169] As of 2016, rural vacancy rates were 21 percent for family physicians, 17 percent for Family Nurse Practitioners, and 19 percent for Physician Assistants. Most physicians live in areas with over 1,000 people and 69 percent are located in the Anchorage/Mat-Su region.[168] There are also many vacancies in tribal-health occupations such as CHAs and practitioners (102); behavioral health aides, therapists, and village counselors (18); and dental health aides and therapists (10).[168]

For example, by 2030 the state will need 237 primary care physicians, a 49 percent increase from the state's current 486 active family medicine/general practice physicians.[168] Additionally, the state has high levels of medically underserved areas/populations (MUAs/MUPs). These areas designated by HRSA have high infant mortality, poverty, and elderly population, as well as few primary care physicians. MUA/MUPs cover 78 percent of Alaska's population and 95 percent of the land mass.[168] The state also faces challenges retaining trained health care providers to serve many small villages.[145] The *Report of the Alaska Physician Supply Task Force* stated that communities may be too small, too poor, or too disadvantaged in geographic competition to support sufficient viable physician practices, and may not have the economic wherewithal to support more physician practices even though physician-to-population ratios may indicate they are needed.[170] The report also noted the state's trend toward hospitals hiring physicians, relying on emergency medicine specialists to staff ERs, and having clinics with combinations of physician and advanced nurse practitioners and physician assistants.[170]

Chapter Summary

Assessment of selected health reforms of the past decade highlights the flourishing of myriad reforms addressing the triple aim, not only launched by SB 74 but in response to the increasing number of federal funding opportunities to pilot payment and delivery system reforms. The AKHCC's comprehensive set of recommendations (2014) offer a relatively recent benchmark, reflecting multiple stakeholder perspectives and the evidence base to date. Much of the reform activity taken on since 2015 has yet to be formally evaluated.

Chapter Seven: Paths Forward: Learning from Alaska's Recent Health Reform History

In this chapter, we present an initial set of observations about possible pathways forward for health reform in Alaska, building on the AKHCC recommendations and on the findings presented earlier in this report. These observations are intended to supplement findings from the meta-analysis report; together, the historical project scan and meta-analysis lay groundwork for the second two reports that the NORC team is preparing for the PMC.

Building on the AKHCC 2014 Recommendations: What Have We Learned?

AKHCC recommendations made by the state's multiple stakeholders provide a fundamental starting point for considering lessons of the recent past.[44] AKHCC's strategic map offered four priorities (high-quality, affordable health care; accessible, innovative, patient-driven care; healthy Alaskans; and a sustainable, efficient, effective health care system), and eight core strategies to implement these priorities.

Since these recommendations were issued in late 2014, limited evidence is available to reassess or substantially add to AKHCC's overarching set of detailed recommendations. Our historical scan identifies the following findings in Exhibit 11 below.

Exhibit 11: Historical Scan Findings Aligned With Selected AKHCC Recommendations

HCC Recommendations	Findings from research	Missing Information	Opportunities for further reform (gaps)
Ensure that the best quality evidence is used	Evaluations have the potential to offer locally relevant, actionable guidance	There are few evaluations of reforms launched in the past decade	Add evaluation requirement to health reform initiatives
Increase price and quality transparency	The Oregon Health & Science University's Center for Evidence – Based Policy study on alternative payment models in the AK Medicaid Pharmacy program and the new pricing benchmarks for drugs addressed this.	Few reforms address this recommendation.	While there has been some movement around drug pricing, more transparency around the cost of care is needed
Design payment structures to incentivize quality, efficiency, effectiveness	**(Increased purchasing power for consumers)** The AK reinsurance program under HB 374, made possible by a tax on insurance, substantially reducing premiums. It is expected that 1, 4600 individuals will be able to gain access to insurance as a result. **(Incentivizing quality with minimum risk to providers)** Under Medicaid Redesign, United HealthCare's Managed Care Model is enrolling beneficiaries in a capitated per member per month model. BPCI tested bundled payments, aligning incentives for multiple provider types.	The studies we looked at focused on reducing fraud, waste, and abuse. Whether the ACOs recommended by the Medicaid Redesign Project have been formed is unknown.	Section 2703 Health Homes has the potential to incentivize providers to provide care management, but it has not gotten off the ground yet. The ACOs recommended under Medicaid Redesign Project Initiative 5 would help meet this recommendation by organizing providers into shared/savings/shared losses models, which would improve quality while shielding provides from taking on too much risk.

HCC Recommendations	Findings from research	Missing Information	Opportunities for further reform (gaps)
Enhance quality and efficiency of care on the front-end	The role of primary care providers is currently being strengthened through the Nuka program through the provision of holistic care incorporating traditional medicine and western medicine. Dental aides, community health aides, and other physician extenders. Complex Behavior Collaborative has been instrumental in improving coordination of care for patients with multiple providers and managing chronic behavioral and mental health conditions. A great example regarding tools and resources to improve primary care provision is the Prince of Wales Health Network connecting individual to local resources. The frontier extended stay clinics have also focused on providing an acute care setting for the recovery of individuals who live in remote areas; for them to recover.	There are not enough reforms focusing on pediatric care. There is a need for more explicit tools for making health care decisions.	Recommend developing a roadmap for clinical decision making.
Enhance quality and efficiency of care on the front-end	The CDC 6|18 initiative has focused on this by focusing on tobacco prevention and cessation, diabetes prevention via access to the National Diabetes Prevention Program, and hypertension management via medication management and teach-based care approaches. The Prince of Wales network has focused on creating a collaborative network that has focused on a range of public health initiatives, including increasing access to and awareness of healthy foods and offering suicide prevention training. Housing first initiative reduced emergency service usage decreased, use of outpatient services increased, medication adherence improved, and alcohol usage declined. Children programs such as the Help Me Grow have begun to fill a need in providing primary and developmental screening to kids.	There is a need to reduce cost of care overall for individuals who live in permanent supportive housing. No evaluations on the Help Me Grow programs. Lack of children programs overall Lack of health reform on vision care	Recommend developing including vision care and pediatric care in the health care reform conversation.
Build the foundation of a sustainable health care system	Data analytics: The Kana electronic reminder system. Alaska's Tribal Health System has led the way in terms of EHRs use and interoperability and telemedicine. AFHCAN has and continues to play a major role in expanding telehealth capabilities across the state.	Thorough evaluation on the electronic systems in the IHS and rates of implementation. EHR capacity of remote sites	AK has evolved with regards to its connectivity and capacity for EHR. While these efforts have set the stage for data analytics, few reforms/efforts have tested or substantially utilized data analytics as a means of improving population health.

HCC Recommendations	Findings from research	Missing Information	Opportunities for further reform (gaps)
	Health workforce capacity: ANTHC's training programs remain promising models.	Evaluation of impacts on quality of care.	Continue to support training and reimbursement of mid-level and non-clinically trained providers (e.g., patient navigators, care coordinators)

Possible Pathways to Reform

Short-term and long-term policy change

- Leverage the historical experience of Alaskan public officials and stakeholders with multi-sector planning coalitions that bring all parties to the table—both Native and non-Native, state and private sector, federal and state, providers and payers—following the highly-regarded examples of health systems planning and the certificate of need process that began in the 1970s and more recently, with the Healthy Alaskans 2020 planning process. Sustained engagement to define the scope of reform, for example, to place social determinants of health more squarely inside focus of reform, is likely to be more robust and gain great acceptance and engagement.

- Continue to use the AKHCC's comprehensive set of recommendations around primary care reform as a launching point but acknowledge that PCMH, as a delivery system reform that may be yoked to diverse payment schemes, may not necessarily yield desired, substantial cost savings over the long term. For example, greater access to specialists and hospitals enabled by coordinated care may contribute to higher health care costs. While the Nuka model is an internationally acknowledged touchstone for primary care reform, there are multiple challenges to replication or scaling outside of the tribal system. The capability of ANTHC as a delivery system to braid or align multiple revenue sources around coordinated care, and the substantial investment in cultural change within the health care organization, toward an emphasis on relationships between customer-owners and clinicians, may not be readily realized outside of the Southcentral Foundation.

- Continue to invest in strategies to bridge the great distances that separate many of the state's residents from each other and from essential health services and programs that address non-medical SDOH. Published evaluations provide evidence of the efficacy of reforms in telemedicine (including broadband access in remote parts of the state), workforce development that taps Alaska residents for training and employment (e.g., the aide programs developed by the tribal system), and payment reforms that support coordination across the continuum of care (e.g., the specialty co-management model of Project ECHO) and across settings (e.g., the Extended Frontier Clinic model that stabilizes residents after hospital discharge and before returning to community living).

Programmatic changes

- Identify nationally-validated performance measures that are meaningful to health reform in the state and support their addition to current state data systems (e.g., claims submitted for Medicaid reimbursement).

- Invest in evaluation of health reforms, and in local capacity to design and conduct evaluations, to give a rigorous evidence base that can guide reform tailored to the needs, experiences, and expectations of Alaska residents.

System redesign changes

- Acknowledge the defining characteristics of health services delivery in the state over time, deeply oriented towards fee-for-service reimbursement and shaped by the dynamic between federal and state-level organization and revenues and that of local autonomy. Consider reforms that take advantage of these characteristics of existing delivery systems.

- Continue to re-align Medicaid purchasing with federal reform opportunities through the waiver programs, for example, system redesign opportunities under section 1115, reinsurance that was successful in shoring up the ACA marketplace under section 1332, and greater investment in rebalancing long-term services and supports from institutional to home- and community-based services under section 1915 waivers.

- Support greater coordination across health services delivery and social services as a promising approach to address the contributions of SDOH to adverse health outcomes. For example, the Housing First evaluation finds that an integrated approach is associated with improved health and wellbeing for at-risk, formerly homeless residents; however, cost savings were not seen with this model.

Chapter Summary

The historical sketch of Alaska's health reform landscape offers themes to consider as the Alaska Healthcare Transformation Project continues to do its work. These themes or preliminary ideas are suggestions for further analysis, to inform development of the NORC team's third and fourth reports. Together, all four NORC team reports will contribute to creation of a roadmap for health reform, both in the short-term (under 12 months' time) and in the long-term (the next five to ten years).

Appendix A: Glossary of Acronyms and Terms

Exhibit A.1: Project Glossary

Acronym	Definition
AAPM	Advanced Alternative Payment Model
ACA	Patient Protection and Affordable Care Act
ACF	Administration for Children and Families
ACO	Accountable Care Organization
AFHCAN	Alaska Federal Health Care Access Network
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian/ Alaska Native
AICS	Alaska Island Community Services
AIM	Alaska Innovative Medicine program
AKDHSS	Alaska Department of Health and Social Services
AKDOA	Alaska Department of Administration
AKHCC	Alaska Health Care Commission
AKPCA	Alaska Primary Care Association
AMCCI	Alaska Medicaid Coordinated Care Initiative
AMHTA	Alaska Mental Health Trust Authority
ANMC	Alaska Native Medical Center
ANTHC	Alaska Native Tribal Health Consortium
AOTF	Alaska Opioid Task Force
API	Alaska Psychiatric Institute
APM	Alternative Payment Model
ARTN	Alaska Rural Telehealth Network
ASO	Administrative Service Organization
BIA	Bureau of Indian Affairs
BPCI	Bundled Payments for Care Improvement
CCA	Care Coordination Arrangements
CCD	Coordinated Care Demonstration
CDC	U.S. Centers for Disease Control and Prevention
CHAP	Community Health Aide Program
CHC	Community health center
CHIP	State Children's Health Insurance Program
CIT	Mat-Su Borough Crisis Intervention Team Coalition
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
DOD	U.S. Department of Defense
DRG-PPS	Diagnosis-related group prospective payment systems
ECHO	
ED	Hospital emergency department
EHR	Electronic health record, electronic medical record
EMS	Emergency medical services
FFS	Fee-for-service
FORHP	Federal Office of Rural Health Policy
FQHC	Federally qualified health center
GAF	Geographic Adjustment Factor
HCA	Health Care Authority
HCIA	Health care innovation award

Acronym	Definition
HCP-LAN	Health care payment learning and action network
HHS	U.S. Department of Health and Human Services
HIE	Health information exchange
HIT	Health information technology
HMO	Health management organization
HRSA	Health Resources and Services Administration
HUMS	High-Utilizer Mat-Su program
IAP	Medicaid Innovation Accelerator Program
IHS	Indian Health Service
KANA	Kodiak Area Native Association
MC	Managed care
MCO	Managed care organization
NCQA	National Committee for Quality Assurance
NGA	National Governor's Association
PBM	Pharmacy benefit manager
PCMH	Patient-Centered Medical Home
POWHN	Prince of Wales Health Network
PMC	Project Management Committee
PTN	Patient transformation network
PW GPCI	Physicians Work Geographic Practice Cost Index
RHC	Rural health center
SB 74	Alaska Senate Bill 74 (Medicaid reform)
SDOH	Social Determinants of Health
SEARHC	Southeast Alaska Regional Health Consortium
SIDS	Sudden infant death syndrome
SMHP	State Medicaid HIT Plan
SNF	Skilled nursing facility
STD	Sexually transmitted disease
TB	tuberculosis
TCPI	Transforming clinical practice initiative
TRUST	Target Rural Underserved Track Program
USDA	U.S. Department of Agriculture
VA	Veterans Administration
VBP	Value-based purchasing
WICHE	Western Interstate Commission for Higher Education

Appendix B: List of Health Reform Experiments

Exhibit B.1: Initial List of Experiments Submitted to the PMC

Name of Reform Experiment	Years	Topic(s) of Focus	Region
Nuka System of Care (Southcentral Foundation)[112]	1999 - Present	Primary care, coordinated care, social determinants of health	Anchorage, Matanuska-Sustina Valley, Rural Anchorage Service Unit
Alaska Wellness Warriors Initiative[171]	2004-Present	Social determinants of health	Statewide
Prince of Wales Health Network[154]	2008-Present	Primary care, coordinated care, social determinants of health	Prince of Wales Island
Alaska Women's Recovery Project[172]	2008-Present	Social determinants of health	Anchorage
Targeted Rural Underserved Track (TRUST) Program[70,149,173]	2008-Present	Primary care	Statewide
Colorectal Cancer (CRC) Screening Patient Navigator Demonstration Project (Alaska Native Tribal Health Consortium)[174]	2009-2010	Primary care	Not specified
Alaska Health Care Commission[1, 44]	2009-2015	Primary care, payment reform, social determinants of health	Statewide
Kodiak Area Native Association electronic clinical reminders[112]	2009-2011	Primary care	Kodiak
Alaska Health Workforce Coalition[175]	2010-Present	Primary care	Statewide
FQHC Advanced Primary Care Practice Demonstration[83]	2011-2014	Primary care, coordinated care	Anchorage
Patient Centered Medical Home Pilot Program (3 clinics)[66]	2011-2014[ii]	Primary care, coordinated care	Wrangell, Talkeetna, Bethel
Ukudigatunal Wellness Center - Implementation of the IHS Improving Patient Care Collaborative[63]	2011-2012	Primary care, coordinated care	Aleutian Islands
Housing First[158]	2011-Present	Social determinants of health	Anchorage, Fairbanks
Complex Behavior Collaborative[73,176]	2012-Present	Coordinated care	Statewide
Health Care Innovation Awards: Peacehealth Ketchikan Medical Center[177]	2012-2015	Primary care, coordinated care	Ketchikan and Craig
Strong Start for Mothers and Newborns Initiative – Birth Center Approach[87]	2012-2016	Coordinated care	Anchorage, Juneau, and Wasilla
Alaska Medicaid Coordinated Care Initiative[47,70]	2014-Present	Coordinated care, data analysis	Statewide
Alaska Patient Centered Medical Home Initiative[66,68]	2014-Present	Primary care, coordinated care	Statewide
Bundled Payments for Care Improvement: Model 2 and 3 (The Alaska Hospitalist Group/Liberty Health Partners)[178,179]	2014-Present	Coordinate care, payment reform	Anchorage
Medicaid expansion[117]	2015-Present	Payment reform	Statewide
Transforming Clinical Practice Initiative[180,107,181]	2015-2019	Payment reform, data analysis	Statewide
Healthy Alaska Medicaid Redesign (SB 74)[182] Coordinated Care Demonstration Projects (in RFP/award phase)[47]	2016-Present	Payment reform, coordinated care, data analysis	Statewide

[ii] Based on the available information online, the team was unable to confirm the end date of the PCMH pilot program.

Name of Reform Experiment	Years	Topic(s) of Focus	Region
Behavioral health system reform (see 1115 submission, below) Quality & cost-effectiveness targets[183]			
Alaska Reinsurance Program (1332 waiver approved in 2017)[121]	2016-Present	Payment reform	Statewide
Alaska Early Childhood Comprehensive Systems Impact Project[184]	2016-2021	Coordinated care, social determinants of health	Norton Sound Region, Matanuska-Susitna Borough, Kodiak Island
Million Hearts: Cardiovascular Disease Risk Reduction Model[106]	2017-2022	Primary care, data analysis	Anchorage
6/18 Initiative (CDC)[152]	2017-Present	Coordinated care, social determinants of health	Statewide
Alaska Primary Care Association Apprenticeship programs[185,186]	2017-Present	Primary care	Statewide
Bundled Payments for Care Improvement Advanced[131]	2018-2023	Coordinate care, payment reform	Anchorage
Medicaid Section 1115 Behavioral Health Demonstration Application (pending)[187]	2018-Pending approval	Primary care, coordinate care, data analysis, social determinants of health	Statewide

Appendix C: Supporting Materials, Key Informant Interviews

Exhibit C.1: List of Interview Respondents

Name	Affiliation	Interview Date	Interview Lead
Scott Wittman	Pacific Health Policy Group	12/12/18	NORC
Lori Wing-Heier	Division of Insurance	1/16/19	ISER
Jeff Jessee	College of Health at UAA	1/17/19	ISER
Karen Perdue	Fairbanks Memorial Hospital	1/21/19	NORC
Douglas Eby, MD	Southcentral Foundation	1/24/19	ISER/NORC
Gene Quinn, MD	Alaska Heart Institute	Scheduled for 2/8/19	NORC
Jeffrey Davis	United Healthcare	To be scheduled	NORC
Kevin Moore			

Note: Additional interviews are expected to be conducted over the course of the project.

Exhibit C.2: Initial Email for Outreach to Prospective Key Informant

Dear [NAME],

NORC at the University of Chicago (NORC) in partnership with the Institute for Social and Economic Research (ISER) are requesting your input for a study of past health reform efforts in Alaska to support the Alaska Healthcare Transformation Project. The information you provide will give us important information for understanding previous health reform experiments in Alaska and the context in which they were conducted.

We invite you to participate in a telephone interview to share your knowledge of Alaska's health reform efforts. We have identified you as a subject matter expert with deep expertise and believe that you will have valuable insights to contribute to this study. The telephone discussion will last no longer than one hour. Participation in the study is voluntary. You may choose not to answer any questions that you do not wish to answer. You can end your participation at any time. There are no expected risks to participating in this telephone interview. All information collected for this study will be kept secure.

If you are willing to participate in a telephone interview, please reply to this email or contact [NORC Staff Member] at [email] or [telephone number]. Please also indicate any preferred dates and times for the discussion.

Your participation is very important to help us understand the state of health reform in Alaska.

If you have any questions, please contact the NORC Project Director, Scott Leitz (Leitz-Scott@norc.org, 312-357-7038).

Sincerely,
[SIGNATURE BLOCK]

Exhibit C.3: Follow-up Email to Prospective Interview Respondent

Dear [NAME],

Thank you for agreeing to an interview with our team, regarding past health reform efforts in Alaska, as part of the Alaska Healthcare Transformation Project. The information you provide will help us better understand the history behind current reform efforts and lessons learned.

Your interview is scheduled for [insert date and time]. At that time, please call the following toll-free number (1-866-215-5503) and when prompted, enter your participant code (5483 192#). Colleagues from the Institute for Social and Economic Research (ISER) may join us on the conference call as well.

Before your interview, we'd like to ask for your help to identify (1) health reforms that are familiar to you and (2) people whom you would recommend that we contact for information about other reforms that may not be as familiar to you. Your response will help us tailor interview questions to make best use of your time. We have listed a number of health reform initiatives in the table below.

Please reply to this email, including the table below and adding your answers to this table. If you would prefer, we are glad to receive your feedback as email text or another format, whatever is convenient for you.

Category of Initiative	Examples	(1) Please note if you have experience with one or more of these reform initiatives	(2) Please indicate here if you know someone else you'd recommend we talk to about a specific initiative
Alaska Native/Tribal initiatives	• Nuka System of Care • Alaska Wellness Warriors Initiative • Alaska Women's Recovery Project • Colorectal Cancer Screening Patient Navigator Demonstration Project • Kodiak Area Native Association (KANA) Electronic Clinical Reminders • HIS Improving Patient Care Collaborative		
State-led health reform efforts	• Alaska Health Care Commission • Alaska Patient-Centered Medical Home (PCMH) Initiative • Complex Behavior Collaborative • Alaska Medicaid Coordinated Care Initiative • Healthy Alaska Medicaid Redesign • Alaska Early Childhood Comprehensive Systems Impact Project		
Community/social services initiatives	• Prince of Wales Health Network • Housing First • Coordinated Re-entry Corrections		
Provider-led initiatives	• Alaska Innovative Medicine • Peacehealth Ketchikan Medical Center (Health Care Innovation Award) • Ukudigatunal Wellness Center • Pinnacle Integrated Medicine • Help Me Grow Alaska		
Workforce initiatives	• Alaska Health Workforce Coalition • Alaska Primary Care Association Apprenticeship Programs • Target Rural Underserved Track Program		
AK participation in federal innovation initiatives	• FQHC Advanced Primary Care Practice Demonstration • Peacehealth Ketchikan Medical Center		

Category of Initiative	Examples	(1) Please note if you have experience with one or more of these reform initiatives	(2) Please indicate here if you know someone else you'd recommend we talk to about a specific initiative
	• Strong Start for Mothers and Newborns Initiative • Bundled Payments for Care Improvement: Models 2 and 3 • Transforming Clinical Practice Initiative • PCMH Pilot Program • CDC's 6/18 Initiative • Million Hearts: Cardiovascular Disease Risk Reduction Model		

Your participation is very important to help us understand the state of health reform in Alaska. Thank you again!

If you have any questions, please contact the NORC Project Director, Scott Leitz (Leitz-Scott@norc.org, 312-357-7038).

Sincerely,
[SIGNATURE BLOCK]

Exhibit C.4: Protocol, Semi-Structured Interview

Alaska Historical Scan: Interview Protocol, version 5

I. Overview and Instructions for Interviewer(s)

Goals

This semi-structured interview will explore the respondent's knowledge of health reform in Alaska. The goals of these interviews are to understand (1) how policy influentials in Alaska think about the history of health reform in their state; (2) to identify, prioritize, and characterize health reform experiments in Alaska over the past decade; (3) to understand what respondents have learned from their participation in health reform experiments and observations of other experiments in the state; and (4) respondents' reflections on the future of health reform in Alaska.

Design

The interview will take two parts: an email request for information from the respondent and a follow-up telephone interview.

- *Once a respondent has been scheduled for an interview, we will send an email request for information. This email will introduce the historical scan study and the purpose of the interview. It will include a list of Alaska health reform experiments for the respondent to review. We will ask the respondent to answer two questions via email regarding the list: (1) to note which experiments are familiar and about which they could speak during the interview; and (2) to identify prospective informants for experiment with which they are not familiar. This exchange will help us to refine the interview protocol ahead of time and to arrange for additional interviews with other respondents.*

- *Each telephone interview will be conducted by one interviewer with one participant. One or more members of the NORC team may listen to the interview but not ask questions. Interviews will be audio-recorded. The interviewer will take handwritten notes during the interview, to help keep track of what they have covered and to remind them of statements made by the respondent that the interviewer might want to reference later on. After the interview, the interviewer will clean their notes and send both cleaned notes and audio recording of the interview to NORC. Once the team has used the recording to annotate the cleaned notes, the recording will be destroyed.*

Interview Time

Each interview should take approximately one hour, including informed consent. Additional time will be used to prepare and check recording technology, reviewing this protocol, and debriefing.

Debriefing

The interviewer will prepare a short written memo or debrief after each interview, in consultation with NORC team members who may have listened in on the interview. The debrief will consist of a brief summary, highlighting themes, key points to note in the analysis, and names and/or affiliations of contacts suggested by the respondent.

Question Types

Three types of questions are used in this interview protocol.

- *Lead Questions (LQ) are asked at the beginning and throughout each section to capture the primary goals of the section.*
- *Additional Questions (AQ) typically address major goals within a Lead Question topic. If the respondent does not address these topics in response to the Lead Question, the interviewer should ask the Additional Questions.*
- *Probes (P) are questions or words designed to capture salient information in each section. If the respondent does not address these topics in response to the Lead or Additional Questions, the interviewer should use the probes. The interviewer can and should always use more general probes, as needed.*

All questions are intended to guide the interviewer to gather all the data of interest for the study. The questions are not meant to be asked exactly as they are written. For each interview, the interviewers should consider the best way to gather the data and rephrase questions as needed to address the questions' intent.

Interview Strategy

The basic strategy is to begin with the Lead Question and the follow up with the Additional Questions. Probes should be used if a respondent has not addressed a particular topic or issue in their responses to Lead or Additional Questions. If relevant data emerge for which there is no probe, the interviewer should ask clarifying questions and/or use general probes to follow up on emergent (unexpected) themes.

Within the limits of a one hour interview, the interviewer should focus on addressing 1 to 2 topic areas and no more than a few health reform experiments. The respondent's answers to the follow-up email ahead of the interviewer, together with information shared earlier in the interview, can guide the interviewer in narrowing the scope of the interview.

II. Informed Consent

The intent of this portion of the interview guide is to explain what a participant should expect during this interview and get their official consent to participate. It is also a chance to make a good first impression and build rapport with the participant and make him or her as comfortable as possible by explaining the interview, letting him or her know what to expect from the experience, and emphasizing that the participant is the expert here.

The interviewer will read the consent language below to the respondent.

My name is [*name of interviewer*]. I am joined today by [*name colleagues listening to interview*]. As you know, we are under contract to the Alaska Healthcare Transformation Project, to help develop a road map for health reform in Alaska. As part of this project, we are writing a background report about the history of health reform in the state since 2008. Our history will be based on a literature review and a small number of interviews.

Thank you for agreeing to be interviewed as part of this project. We look forward to hearing from you. We are especially interested in learning about the reform efforts in which you've been involved, as you indicated in your response to our email before this call. Some of our questions for you may be based on these specific reform initiatives.

Before we get started, we have a few housekeeping issues to mention:

- We've scheduled this interview to last up to 60 minutes. We'll do our best to stick to this schedule. If you need to stop for any reason, that's fine. We know that you are busy and your participation is voluntary. If you do end the interview early, we would like to keep and analyze any information that was collected before you ended the interview. However, we will also honor any request that the data is destroyed or that we exclude your data from any analysis.
- If questions come up after we finish our discussion today, please feel free to contact me or our project director, Scott Leitz. Scott is at (312) 357-7038. My phone number is [*number for interviewer*].
- As much as we want to hear what you have to say, it is completely okay for you not to answer any question if you don't want to.
- We won't share anything that you have said as coming from you personally. What you say here will be kept confidential.
- We are taking notes during the interview so we can write our report. We would also like to record our discussion, to make sure we don't miss anything you tell us. The recording and our notes will be saved on NORC's secure server. The recording will be transcribed. This will allow the study team to analyze the information in your interview and to write a report. We may use excerpts from the recording as quotes in our reports but we will not link them to your name; instead, you may be identified by your professional title or organizational role.

Once the research project is complete, the recording will be destroyed. If you do not wish to be recorded, you can choose not to participate in the study.

The only anticipated risk of your participation is loss of time. Otherwise, this study does not involve any risks other than what you would encounter in daily life.

Do I have your agreement to participate in this interview and for me to record our conversation?

Are there any questions before we begin?

General Questions

LQ: Could you tell us more about yourself, related to your professional background and work experience?

Additional Questions:

- Your current position?
- What fields do you have education or training in?
- Are you or have you been a health care practitioner?
- How long have you been working in Alaska and in what different roles?
- Have you had similar work experience in other states?

LQ: As you know, we are gathering data about health reform experiments active in Alaska between 2008 and 2018. Our definition of a "health reform experiment" for this project is an activity with the goal of improving the patient or provider experience of care, improving the health of populations, and/or reducing the per capita costs of health care. This can include the implementation of a new health care program, project, or model, creating a new way to collect or use data, or a substantial change to an existing health care policy or program. **In your experience, is this a useful definition of health reform in Alaska?**

Additional Questions

- AQ: What is missing from this definition?
  - P: emphasis or overall meaning
  - P: specific examples of health reform experiment
- AQ: Are there other changes that we should make to this definition?
- AQ: Are there aspects of health reform that are unique to Alaska?
  - P: related to populations, payers, geography, or availability of providers
  - P: compared with other states or jurisdictions?

LQ: We sent an email ahead of this telephone call, with a preliminary list of health reform experiments active in Alaska between 2008 and 2018. Looking over that list, are you aware of any significant experiments that are missing?

If they did not have time to look at the list, ask if it would be helpful for us to summarize on the call.

If they mention any initiatives that we had not found in our research:

- AQ: Would you be willing to tell us a little more about that project later in this call?

- AQ: Do you know where we could find more information on that initiative?
- AQ: Is there anyone else you would recommend that we talk to about that initiative?
- AQ: Are there any health reform experiments you would remove from the list, for example, if they were never fully implemented or are out of scope?
- AQ: Which reform experiments stand out to you as having the most significant impact on the overall direction of health care reform in the state?
- AQ: What do you see as the most significant gaps in recent health reform efforts in Alaska?
    - P: certain regions not represented or under-represented
    - P: specific populations
    - P: types of services (e.g., physical health, behavioral health, dental, vision, social services, long-term care)
    - P: specific payers
    - P: other gaps?

III. Questions About Task Force's Five Topics of Interest

LQ: Our research is focused on health reform in Alaska in five topic areas: primary care, coordinated care, data analytics, payment reform, and social determinants of health. In which of those areas do you have experience?

- Great, we will ask you more about those areas/that area in a minute.
- *AQ: If not addressed above:* Do you see any of these areas as gaps in health reform efforts in the state?

LQ: We are going to ask a similar set of questions for each area that you've mentioned. [*note to interviewer: probably time to ask about no more than two areas*]

Repeat the following questions for each topic area that the interviewee is able to speak to:

- AQ: Could you summarize the current status of health reform in Alaska related to [topic area] from your perspective?
- AQ: What structural pieces are currently in place in Alaska to facilitate reform in this area?
- AQ: Who are the major stakeholders involved in health reform in this area?
- AQ: What has been the most significant progress in this area in the past decade, from your perspective?
    - P: Most notable initiatives or reforms implemented in this area?
- AQ: To your knowledge, have any of the experiments had a measurable effect on quality, access, or cost/spending in Alaska?
- AQ: Are there any recent reforms in this area that have stalled or have not been successful?
    - P: why not successful?
- AQ: What have been the most significant challenges or barriers for Alaska in moving forward with [topic area]?
    - P: factors shared by other states trying to reform?
    - P: factors unique to Alaska?

- AQ: What do you see as the biggest opportunities for health reform in this area in the next 5-10 years?
  - P: what goals to address?
  - P: how realistic or actionable?

IV. Questions About Specific Health Reform Experiments

LQ: Have you been involved in the implementation or evaluation of experiments on our list? Which ones?

If the interviewee has experience with one or more of the initiatives, please ask the series of questions that follow. If the interviewee has experience with more than one initiative, repeat this section for each one if time permits.

Also ask the questions below for any initiatives the interviewee mentioned that seem to be within the scope of our project, but were not on our initial list.

- AQ: What is/was your role?
- AQ: What are/were the primary goals of this initiative?
- AQ: What is the current status of the initiative?
- AQ: In what region or regions of the state is/was this initiative active?
- AQ: What populations are/were served by this initiative?
- AQ: What outcomes, if any, were measured/are being measured for this initiative?
  - P: Are results available so far?
- AQ: How is/was the initiative funded?
- AQ: Is any information available on the cost of the initiative, and/or its impact on health care costs?
  - P: how was cost measured/evaluated and validated?
- AQ: What have been the lessons learned from this initiative?
- AQ: What are the implications for future health reform efforts in Alaska, in terms of policy changes, programmatic changes, and/or system redesign prospects?
- AQ: Has the initiative been replicated or expanded elsewhere in the state?

Add any other questions that are necessary to understanding the initiative.

V. Closing

LQ: That is it for our questions. Is there anything I didn't' ask about that you think is important for us to know?

Thank you for talking with us today. Your time is very much appreciated. Please feel free to contact us at any time with further questions or thoughts about the Alaska Healthcare Transformation Project.

Appendix D: Matrices of Health Reform Experiments

- Nuka System of Care
- Prince of Wales Health Network
- Kodiak Area Native Association Electronic Clinical Reminders
- FQHC Advanced Primary Care Practice Demonstration
- Complex Behavior Collaborative
- Health Care Innovation Awards: PeaceHealth Ketchikan Medical Center
- Strong Start for Mothers and Newborns Initiative – Birth Center Approach
- Alaska Medicaid Coordinated Care Initiative (AMCCI)
- Alaska Patient Centered Medical Home Initiative
- Bundled Payments for Care Improvement: Models 2 and 3
- Transforming Clinical Practice Initiative

Nuka System of Care	
Overview	
Funder	Southcentral Foundation
Location	Anchorage, Matanuska-Susitna Valley, Rural Anchorage Service Unit
Contact Person (s)	Douglas Eby, M.D.
Goal of Experiment	Relationship-based, customer-owned approach aiming to transform health care, improve outcomes, and reduce costs.
Current Status	Ongoing
Results	
Measureable Outcomes	▪ 95% of members are assigned to integrated primary care team. ▪ Reduced average delay to schedule routine appointment from 4 weeks to same-day access. ▪ 36% reduction in hospital days. ▪ 42% reduction in ER and urgent care usage. ▪ 58% reduction in specialty clinic visits sustained over 10 years. ▪ Met 75th percentile of 75% of HEDIS measures (national standards). ▪ Met 95th percentile for diabetes care. ▪ In a 5 years, staff turnover has decreased by 25%. ▪ 25% increase in childhood immunizations. ▪ Customer satisfaction with respect for their cultures and traditions at 94%.
Experiment Cost	Foundation has a $349 million budget[188]
Population Served by Payer	65,000 individuals in the Native community across 55 rural villages
Payment Structures Used or Proposed	Customer-ownership
Future Opportunities	
Lessons Learned	▪ Provides a dramatically different care experience than what was encountered under the government-run program in the same region. ▪ Better relationships between patient and providers, healthier patients, and a 'healthier' organization.[60]
Recommendations Resulting from Experiment	Explore the feasibility of employing a customer-ownership model in other AK health care settings.
Missing Information	N/A

Prince of Wales Health Network	
Overview	
Funder	FORHP and Alaska Community Foundation
Location	Prince of Wales Island
Contact Person (s)	N/A
Goal of Experiment	Build strong and sustainable network of healthcare organizations collaborating to strengthen local healthcare system and increase access to quality healthcare for all island residents
Current Status	Ongoing
Results	
Measureable Outcomes	Increased the collaboration and cooperation among healthcare facilities and other organizations, leading to enhanced healthcare services for island residents while eliminating unneeded duplications and filling in service gaps.[189]
Experiment Cost	Unknown
Population Served by Payer	Residents of Prince of Wales Island
Payment Structures Used or Proposed	N/A
Future Opportunities	
Lessons Learned	Reputable community resource functioning as a grassroots initiative with the aim of improving the care of the community.
Recommendations Resulting from Experiment	Build networks that foster synergy and collaboration and reduce duplication of services with the goal of connecting individuals to services.
Missing Information	Program evaluations Program cost

Kodiak Area Native Association Electronic Clinical Reminders	
Overview	
Funder	Indian Health Service
Location	Kodiak
Contact Person (s)	N/A
Goal of Experiment	KANA sought to actively improve key preventative screening rates for its patients.
Current Status	Complete
Results	
Measureable Outcomes	Data from 2007-2011 show screening rates for all 5 measures (depression, tobacco cessation, intimate partner violence, alcohol abuse, and cardiovascular disease) improved considerably, to levels significantly above the national average for IHS facilities.
Experiment Cost	Unknown
Population Served by Payer	Kodiak Natives and those living in 6 surrounding villages.
Payment Structures Used or Proposed	N/A
Future Opportunities	
Lessons Learned	▪ Clinical reminders have been a key part of a multistep process to improve screening for depression, tobacco cessation, intimate partner violence, alcohol abuse, and cardiovascular disease. ▪ If deployed correctly, reminders are valuable tools in identifying patients who are overdue for preventative health screenings.[190]
Recommendations Resulting from Experiment	At a programmatic level, electronic clinical reminders could be scaled and spread to other settings.
Missing Information	Outcome Cost Impact

FQHC Advanced Primary Care Practice Demonstration	
Overview	
Funder	Centers for Medicare and Medicaid Services
Location	Anchorage
Contact Person (s)	N/A
Goal of Experiment	Test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients.
Current Status	Complete
Results	
Measureable Outcomes	▪ While evaluation results specific to AK are not available, national results from 503 participating sites found the following: ➢ 70% of sites achieved NCQA Level 3 PCMH recognition (relative to comparison sites) ➢ Over time, beneficiaries at recognized FQHCs had better utilization, process, and cost outcomes; however, outcomes were largely mixed.
Experiment Cost	Unknown
Population Served by Payer	Anchorage Neighborhood Health Center Medicare Population
Payment Structures Used or Proposed	$6 PMPM for medical home services for Medicare enrollees.[191]
Future Opportunities	
Lessons Learned	None demonstrated in Anchorage Neighborhood Health Center.
Recommendations Resulting from Experiment	None specific to Alaska.
Missing Information	▪ Lessons learned from the program ▪ Evidence of cost.

Complex Behavior Collaborative	
Overview	
Funder	Alaska Department of Health and Social Services
Location	Statewide
Contact Person (s)	Joni Stumpe, CBC Program Manager, AKDHSS
Goal of Experiment	▪ Help providers care for Medicaid clients with complex behavioral needs ▪ Help clients live as independently as possible ▪ Avoid Alaska Psychiatric Institute, jail, ERs or out-of-state care
Current Status	Ongoing
Results	
Measureable Outcomes	▪ Of 42 participants, 32 (76%) avoided institutional care ▪ Of 42 participants, 39 (93%) have been able to stay in the community. ▪ Of the 10 (24%) participants requiring a higher level of care, 7 have returned to the community setting.
Experiment Cost	Unknown
Population Served by Payer	Individuals 6 years or older with complex behaviors that present a high risk or danger to the individual and/or others without additional intervention
Payment Structures Used or Proposed	In 2013 the total cost for all BC services for the 42 enrolled participants was $516,233.00 for an average cost per patient of $12,291.[74]
Future Opportunities	
Lessons Learned	▪ Reduced Medicaid costs. ▪ Families have stated the CBC has been beneficial to their families and family members. ▪ Reduction in institutional care, in behaviors that present danger to self or others, and in non-threatening behaviors that constitute a significant problem. ▪ Increased participation in individual's school and work attendance. ▪ Skill set and knowledge base of agency staff has increased.[74]
Recommendations Resulting from Experiment	Outcome results show promise for scaling and spreading this model to other settings.
Missing Information	Lessons learned include vague data and lack quantification of amount of improvement.

Health Care Innovation Awards: PeaceHealth Ketchikan Medical Center	
Overview	
Funder	Centers for Medicare and Medicaid Services
Location	Ketchikan, Craig
Contact Person (s)	N/A
Goal of Experiment	Improve primary care coordination for patients with chronic disease in rural southeast Alaska.
Current Status	Complete
Results	
Measureable Outcomes	▪ Care coordinators contacted 60-80% percent of all patients discharged from the PeaceHealth hospital. ▪ Statistically significant improvement in processes-of-care, driven solely by a 12 percentage point (or 57%) increase in the percentage of patients with diabetes who received all four recommended diabetes process-of-care measures.
Experiment Cost	$3.2 million[86]
Population Served by Payer	Medicare FFS patients with chronic disease in two clinics in rural southeast Alaska
Payment Structures Used or Proposed	Payment provided to two primary care clinics.
Future Opportunities	
Lessons Learned	▪ Improvement in the quality of care, specifically in the increase of patients with diabetes who received diabetes process-of-care measures.[86] ▪ Improvement was consistent with intervention's focus on improving diabetes care and care management.[86]
Recommendations Resulting from Experiment	Produced evidence for improving care coordination that may be translated to other settings.
Missing Information	N/A

Strong Start for Mothers and Newborns Initiative – Birth Center Approach	
Overview	
Funder	CMS, HRSA, and ACF
Location	Anchorage, Juneau, Wasilla
Contact Person (s)	N/A
Goal of Experiment	This initiative aimed to reduce rate of preterm birth and low birth weight infants for CHIP beneficiaries at a high-risk for these outcomes and sought to reduce Medicaid costs during pregnancy, birth, and each infant's first year.
Current Status	Complete
Results	
Measureable Outcomes	▪ Across the 27 awardees, Medicaid beneficiaries enrolled in the Birth Center Model had lower rates of preterm birth, low infant birth weight, and cesarean section compared to similar Medicaid programs not enrolled. ▪ The program also lowered care utilization and costs: compared to similar Medicaid beneficiaries not enrolled, costs from birth through the first year of life were $2,010 lower for Medicaid beneficiaries enrolled in the program. ▪ Program enrollees also had fewer infant emergency visits and hospitalizations. ▪ Outcomes specific to AK sites are not available; however, the Birth Place and Mat-Su Birth Center, both in Wasilla, had 403 and 128 participants with data, respectively.
Experiment Cost	Unknown
Population Served by Payer	CHIP beneficiaries at high-risk for giving birth prematurely.
Payment Structures Used or Proposed	Not applicable
Recommendations Resulting from Experiment	
Lessons Learned	Outcomes demonstrated nation-wide show that the Birth Center Model is a promising approach that Medicaid programs should consider to improve outcomes and lower costs for their covered populations.
Recommendations Resulting from Experiment	▪ This model of care shows promise for replication. Policymakers may look to implementers in AK to learn from their experiences when replicating: Some sites in Alaska struggled with implementing the model amid challenges with staff turnover and lack of staff support.[89] ▪ In contrast, the Mat-Su Birth Center found that peer-counseling improved staff members' ability to identify patients in need of additional support as well as provide breastfeeding support.[89]
Missing Information	There is limited information available on the experiences on the AK sites that participated in this program. More information on their challenges and successes would be helpful for assessing whether the Birth Center Model should be replicated elsewhere in AK.

Alaska Medicaid Coordinated Care Initiative (AMCCI)	
Overview	
Funder	National Governor's Association
Location	Statewide
Contact Person (s)	Zayda Cooper, Division of Health Care Services, AKDHSS
Goal of Experiment	To provide one-on-one case management to individuals with high health care utilization/complex needs.
Current Status	Ongoing
Results	
Measureable Outcomes	The reduction in ED utilization experienced by AMCCI participants saved the Alaska Medicaid program over 8.5 million dollars in 2017. Overall medical services utilization for these participants decreased by 9 percent.[47]
Experiment Cost	Unknown
Population Served by Payer	Alaska Medicaid beneficiaries.
Payment Structures Used or Proposed	Unknown
Future Opportunities	
Lessons Learned	The AMCCI is associated with reduced utilization among Medicaid beneficiaries with high health/care utilization, resulting in cost savings for AK Medicaid.
Recommendations Resulting from Experiment	Providing one-on-one case management for Medicaid beneficiaries with completes needs and/or with high health care utilization shows promise for reducing costs. A rigorous evaluation could provide further evidence of effectiveness and help spur program growth.
Missing Information	While there are some results on the effectiveness of this program, it is unclear if this program has been evaluated rigorously or if there are any plans to do so.

Alaska Patient Centered Medical Home Initiative[iii]	
Overview	
Funder	Capital grant from Alaska State Legislature.
Location	**Pilot stage:** Wrangell, Talkeetna, Bethel **Following stages:** Statewide
Contact Person (s)	N/A
Goal of Experiment	Implement the Patient Centered Medical Home model state-wide.
Current Status	**Pilot stage: Complete** **Following stages:** unknown
Results	
Measurable Outcomes	None demonstrated yet.
Experiment Cost	Unknown
Population Served by Payer	**Pilot stage:** 3 CHCs in Alaska Island Community Services in Wrangell, Sunshine Health Clinic in Talkeetna, and Bethel Family Clinic. **Following stages:** Federally funded community health centers.
Payment Structures Used or Proposed	PCMH pilot sites received one-time grants of up to $75,000 to support practice transformation.
Future Opportunities	
Lessons Learned	None demonstrated yet.
Recommendations Resulting from Experiment	None demonstrated yet.
Missing Information	It is not clear if this program is still active or if it has been evaluated.

[iii] Includes pilot.

Bundled Payments for Care Improvement: Models 2 and 3	
Overview	
Funder	CMS
Location	Anchorage
Contact Person (s)	N/A
Goal of Experiment	To tests whether linking payments for all providers that furnish Medicare - covered items and services during an episode of care related to an inpatient hospitalization can reduce Medicare expenditures while maintaining or improving quality of care
Current Status	Ongoing
Results	
Measureable Outcomes	▪ Across awardees nation-wide, Medicare FFS payments decreased, although overall spending went up as a result of reconciliation payments made to participants. ▪ Fewer patients who received acute care were discharged to an institutional setting. ▪ Patients in SNFs had shorter stays relative to comparison groups. ▪ A report on how bundled payments could be incorporated into AK's Medicaid Program based on BPCI findings as well as other sources found that bundled payments could improve quality of care for maternity and newborn care, although other payment policies could damper effects.[48]
Experiment Cost	Unknown
Population Served by Payer	Physician group practices, hospitals, SNFs, and home health agencies.
Payment Structures Used or Proposed	For both models, actual expenditures were reconciled against a target price for an episode of care via a retrospective bundled payment arrangement.
Future Opportunities	
Lessons Learned	Models 2 and 3 reduced Medicare FFS payments while maintaining quality of care.
Recommendations Resulting from Experiment	The bundled payment model tested by this initiative showed promising results nationwide. To replicate this payment reform, AK can look to participating sites in Anchorage to gain a better understanding of how this could work in an AK context.
Missing Information	Outcomes specific to sites in AK are unknown.

Transforming Clinical Practice Initiative	
Overview	
Funder	CMS
Location	Statewide
Contact Person (s)	N/A
Goal of Experiment	Transforming Clinical Practice Initiative is a large-scale, collaborative effort to help clinicians improve their ability to engage in quality improvement efforts through peer-based learning.
Current Status	Ongoing
Results	
Measureable Outcomes	None demonstrated yet.
Experiment Cost	Unknown
Population Served by Payer	Medical group practices, regional health care systems, regional extension centers, and national medical professional association networks.
Payment Structures Used or Proposed	Not applicable
Future Opportunities	
Lessons Learned	None demonstrated yet.
Recommendations Resulting from Experiment	None demonstrated yet.
Missing Information	It is not clear if this program has been evaluated and it is therefore uncertain how participation in this initiative impacted AK providers' capacity to engage in quality improvement.

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