

# Alaska Healthcare Transformation Project

## A Roadmap for Reform: Appendices

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## Appendix 1: Summary of Data Availability for Private Insurance Coverage

### Overview

To date, analyses of the drivers of Alaska’s health care spending have used aggregated data and information. While this analysis has proven somewhat useful, more detailed analyses are necessary to accurately describe health care spending in a manner conducive to shaping public policy. Conducting such impactful policy-oriented research requires the use of claims data that cover or are representative of all payers, age groups, and facilities, within geographic units that are sufficiently granular to understand regional variation in use and spending. As explained in the main body of this report, Medicare and Medicaid data are available at little cost (although lagged by 12 to 18 months), while data on spending among persons in Alaska with private coverage (e.g., employer sponsored, self-purchased) must be purchased. Private insurance is the main source of health care coverage for the majority of Alaskans, including state employees, retirees, and their families. Table 1 shows the number of subscribers and covered lives who obtain coverage from a commercial insurer.

**Table A1.1. Number of employees and dependents covered as of 2016\***

Entity (As of 2016)	Subscriber	Covered Lives
AK Retirees	41,630	70,300
SOA Employees (includes State Corps)	16,350	40,620
School Districts	15,700	39,960
University of Alaska	3,400	8,000
Political Subdivision	9,200	21,640
Individual Market	18,140	18,140

\*These numbers are current as of 2016. Sources at Segal located these data for a 2017 presentation to ASHNA regarding the HCA.

In coordination with the Alaska Healthcare Transformation Project, NORC and ISER contacted 25 commercial data firms, insurers, and public and private sector employers to understand what data on spending and utilization these firms and purchasers have and what the costs are for obtaining these data. Overall, our recommendation is to not pursue purchasing data from these sources due to low coverage, lack of specificity at the payer and geographic level, and relatively high annual costs. Data from commercial firms had limited coverage (approximately 5.5 to 8.5 percent of the commercial sector) and in general, there is little to no beneficiary/claim level data available from any of the sources investigated with the appropriate payer, facility and geographic information. Annual costs were \$30,000 a minimum per year. Information from these companies can be informative but are not likely to be reflective of the Alaska market landscape. Privacy and legal concerns also make the data acquisition and collection process slow and time consuming. Therefore, we would not recommend purchasing the data for understanding the variation across payers within and compared to other markets outside of Alaska, with respect to the services used and the prices paid by insurance plans and their members. To date, ISER is in the process of obtaining data from the Alaska Facilities Data Reporting Program (HFDR), which collects inpatient and outpatient discharge data and obtaining Institutional Review Board approval. This resource should allow us to better understand how Alaskans interact with hospitals and the prices they face. The Alaska Health Transformation Project purchased the four years of data 2015-2018.

### **Specific Outreach Details**

NORC and ISER team members contacted a total of 24 organizations that held commercial insurance claims data to determine their willingness to share claims data for the purposes of research. We informed the data owners that Alaska would be the purchaser and end user, and that the data would be used to conduct policy-driven analyses, for example, to understand the variation across payers with respect to the services used and the prices paid by insurance plans and their members. The team also explained that data would be analyzed by a research team who would sign a Data Use Agreement (DUA) that would specify the terms and restrictions on access and use.

ISER conducted outreach to 20 organizations (Alaska health insurance brokers, employer trusts, public sector employers, school districts, non-profit employers, and individual private employers); 5 agreed to provide data, 2 are considering it, 11 did not respond or have decided not to share information. This process required a considerable amount of research to identify and contact individuals most knowledgeable and responsible for access to data. ISER contacted organizations with regard to the following information:

- the number of covered lives in claims data for employees across the state and industries,
- availability of high-level summary of spending distribution and patterns.
- availability of de-identified claims level data.

ISER and NORC also contacted four commercial firms to obtain information on the availability and cost estimates for claims data in Alaska for the purposes of research. For each data, we asked for a minimum of the following:

- Provider data: NPI, NPI-TIN or CCN; Specialty code, facility affiliations;
- Claim level data: NPI, place of service, ICD-10, charged and paid amount;
- Plan characteristics: unique identifier on claims or bene enrollment file for plan type that can be linked to a plan-level file on plan benefits; whether NPI paid is network;
- Beneficiary data: enrollment and demographics: age, gender, ZIP code of residence
- Sample codes: office visits CPT= 99213; physical therapy CPT= 97140; emergency department visits = CPT 99284, FH HCPCS: alcohol HCPCS= H0020; comprehensive community support services HCPCS= H2015.

## Appendix 2: Summary Assessment of National Survey and Administrative Data

We examined national survey and administrative data that are commonly used to produce national and state level statistics related to health and to conduct health related research, in the interest of assessing the feasibility of producing state-level and within-state cost and utilization statistics. Overall, we concluded that these data either 1) do not have a sufficient sample size for Alaska 2) do not have the geographic unit (borough or ZIP code) for Alaska (or require special requests for access to restricted data); 3) do not represent respondents from all insurance coverage types in Alaska (necessary for comparability); 4) do not provide all measures of health care costs (e.g., charged amount, insurer payment, out-of-pocket costs) and utilization measures of interest (e.g., inpatient, outpatient, office-based, post-acute). Some data sources may contain indicators of health status only); 5) have restrictions on access and use.

We pursued these national data sets in an effort to obtain all known data sources that could be used for health care policy development. In Alaska, there is currently no single data set or source that is detailed enough to be both descriptive and prescriptive--that is, to allow researchers to describe patterns of usage and healthcare costs over time, across payers, and at the borough level. Hospital discharge data are the best option in Alaska, as these data provide the most granular level data across all payer types, but are far from sufficient for policy planning. They contain charged amounts, rather than final actual payment, and do not provide any identity of payers or plans, only cover hospital events, and researchers cannot obtain both hospital ID and charge information.

Below we describe a variety of survey datasets that can potentially be used to investigate a number of healthcare usage/cost questions as well as their limitations shortcomings. Of course, surveys have the additional issue of being self-reported which comes with error. In addition, we also assessed other secondary national that could provide useful contextual information, such as the American Community Survey (ACS) or the Behavioral Risk Factor Surveillance System (BRFSS) but sources these lack measures of general health care spending and use.

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1. **Medical Expenditure Survey (MEPS):** Medical Expenditure Survey (MEPS): A panel surveys of families and individuals (**Household Component**), providers (**Medical Provider Component**), and insurers (**Insurance Component**) across the United States. These three sets of surveys are designed to provide information on costs of health care, use of health care, and insurance coverage; however they cannot be linked. Data from providers and insurers have restricted access and not available outside an AHRQ Data Center. **The Household Component (MEPS-HC)** is nationally representative sample of households, interviewed five times over two years and collects self-reported health care spending and use.

**Main limitations with respect to health care cost and use analyses:** The MEPS-HC was not primarily designed to facilitate state or local level estimation, the smallest geographic region available in the MEPS-HC data files is census region (Northeast, Midwest, South, and West). Statisticians and other researchers at AHRQ are researching small area estimation techniques in order to produce state level estimates. Currently, data on medical expenditures are only available for the 10 largest states.<sup>1</sup>

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[https://meps.ahrq.gov/mepsweb/data\\_stats/Pub\\_ProdLookup\\_Results.jsp?AuthorString=&TitleString=&pubStartDate=&pubEndDate=&sb=1&SearchButton2=Search](https://meps.ahrq.gov/mepsweb/data_stats/Pub_ProdLookup_Results.jsp?AuthorString=&TitleString=&pubStartDate=&pubEndDate=&sb=1&SearchButton2=Search)

### **Data Access**

<https://meps.ahrq.gov/mepsweb/>

<https://meps.ipums.org/meps>

Access depends on the specific MEPS component. Public use data: there is publicly available data from the MEPS Household Component available online. There are no public release versions of the Medical Provider or Insurance components. The Medical Provider and Insurance, can be accessed through the AHRQ Data Center or Census Bureau's Research Data Center. Researchers must have an approved project to access data through the AHRQ Data Center or one of the Census Bureau's data centers.

**Sample Description:** MEPS-HC targets a sample of 8,600 – 14,800 families, or 21,500 – 37,400 persons per year for full sample. This suggests a relatively small AK representation. MEPS-IC targets about 35 – 40k total establishments, more than half of which are single-location, i.e. firms with one location. About another 3k state and local government units are surveyed each year.

2. **Survey of Income and Program Participation (SIPP):** Series of household level panel surveys. Each panel is nationally representative and spans 2.5 to 4 years. Designed to collect information on program participation and includes healthcare access and use, but household structure, work, and public programs participation. Interview all household members age 15 and over. Health Related Data: pay for insurance premiums, dental visits, health care expenses, doctor visits, hospital stay, whether covered by health insurance, where obtained treatments/services, whether take prescriptions, use/eligibility for Medicaid, Medicare, employer sponsored health insurance, military health coverage, other health coverage, private insurance, high deductible plan, employer sponsored insurance, health savings accounts.

**Main limitations with respect to health care cost and use analyses:** The dataset is very useful but contains a very small Alaska sample-177 households- and the latest panel is from 2014 which makes it inadequate to describe the current conditions in the Alaska Healthcare market. Also the panels only include 1984-1993 (every year), 1996, 2001, 2002, 2004, 2008, and 2014.

### **Data Access**

Publicly available: <https://www.census.gov/programs-surveys/sipp/data/datasets.html>

### **Sample Description**

Focuses on U.S. civilian and non-institutionalized population. Very small sample in Alaska: 177 out of 88,000 in 2010

## **National Center for Health Statistics and the Center For Disease Control and Prevention**

This section describes several data sets that are collected and maintained by the National Center For Health Statistics and the Center For Disease Control and Prevention. These include some survey and some administrative (e.g. vital statistics) data. In general, these data sets have a restricted use version, even if there is a public release version available as well. For restricted data, interested researchers must have a proposal approved to use the restricted data.

3. **National Health Interview Survey (NHIS):** This survey collecting information on the health, health care, health care access, and health behaviors in the U.S. population. While they contain substantial information on health, medical care and access, health insurance, as well as information on demographics, socioeconomic status, state-level data must be accessed and approved by Research Data Center; ZIP code-level data are not permitted.

### **Data Access**

Public release data: <https://nhis.ipums.org/nhis/>

Restricted use data: <https://www.cdc.gov/rdc/b1datatype/dt122.htm>

### **Sample description**

1963 – 2017 on IPUMS. Sample size is about 35,000 households with 87,000 persons per year.

**Main limitations with respect to health care cost and use analyses:** The survey includes questions about delay of care because of cost, the amount of out of pocket costs in the past year, but no information on the cost of procedures. The survey includes questions about delay of care because of cost, the amount of out of pocket costs in the past year, but no information on the cost of procedures.

4. **National Health and Nutrition Examination Survey:** Collected through interviews and physical examinations and used to assess health and nutrition among adults and children in the US. Used to estimate prevalence of disease and related risk factors, assess nutritional status and disease prevention. Collected to represent all ages and includes some oversampling by race/ethnicity and age for reliability.

**Main limitations with respect to health care cost and use analyses:** Does not contain data on health care utilization and spending by respondents.

5. **National Vital Statistics System:**

A collection of data sets related to birth and death records. There are four data sets: Natality Data, Mortality Data, Fetal Death Records, and the Linked Birth-Infant Data files.

**Main limitations with respect to health care cost and use analyses:** These collect information on births, deaths events, but are not usable for state-level or within-state health care utilization or cost analyses

## **National Health Care Surveys**

The following three surveys (National Ambulatory Medical Care Survey, National Hospital Ambulatory Medical Care Survey, and National Hospital Care Survey)

6. **National Ambulatory Medical Care Survey (NAMCS):** Data from medical records of patient visits and interviewing physicians based on a national sample of visits to emergency, outpatient, ambulatory surgery locations. Sample includes non-federally employed office-based physicians who are primarily engaged in direct patient care. Sampling designed to provide national and regional estimates, with some years allowing for estimates of a subset of states. Note: does not include anesthesiology, pathology, and radiology. Sampling is by visits, not people.

### **Data Access**

Public and restricted use versions. Can submit proposal to use restricted data through NCHS Research Data Center. [https://www.cdc.gov/nchs/ahcd/datasets\\_documentation\\_related.htm](https://www.cdc.gov/nchs/ahcd/datasets_documentation_related.htm)

**Sample Description** Current targets are:

- a. 3,000 physician office-based practices
- b. 312 community health center providers
- c. 120,240 patient visits

**Main limitations with respect to health care cost and use analyses:** The general purpose of this study is to collect information about physician practices, community health centers (CHCs), ambulatory patients, their problems, and the resources used for their care. The data is not suitable for health care cost research as it does not include such information and while the design is intended to

provide regional estimates, state level estimates are only available for a limited number of states.

7. **National Hospital Ambulatory Medical Care Survey (NHAMCS):** Includes Emergency Departments, outpatient departments, and Ambulatory Surgery Locations. Important to note that sampling is by visits, not people. Sampling designed to provide national and regional estimates, with some years allowing for estimates of a subset of states. Collects data on Physician and community health center characteristics: specialty, ownership, tests performed, and revenue; patient visit information: vital signs reasons for visit, care, diagnosis, conditions, services, lab test results.

**Data Access**

There are public and restricted access through NCHS Research Data Center.

[https://www.cdc.gov/nchs/ahcd/datasets\\_documentation\\_related.htm](https://www.cdc.gov/nchs/ahcd/datasets_documentation_related.htm) and

[https://www.cdc.gov/nchs/ahcd/rdc\\_data.htm](https://www.cdc.gov/nchs/ahcd/rdc_data.htm)

**Sample Description:** Sampling is by geography. Sample hospitals within geographies, then clinics within outpatient departments: Current targeted sample (annually)

- a. 3,000 physician office-based practices
- b. 410 hospitals
- c. 65,000 patient visits

**Main limitations with respect to health care cost and use analyses:** Similar concerns to the ones listed for the NAMCS as it does not include cost information. The survey is designed to produce accurate national estimates but not necessarily state level ones.

8. **National Hospital Care Survey:** Used to provide statistics related to the use of care, resources, quality of care, and disparities in services. Designed to provide national level statistics. It is possible to link to some other data, e.g. national death index. Utilization of hospital care, inpatient care, care delivered in emergency departments, outpatient departments, and hospital-based or free-standing ambulatory surgery locations. Diagnoses, procedures, lab tests, medications. Data on patient demographics and also include patient level identifiers that help with linking across visits, between inpatient and outpatient episodes, as well as outside databases like the NDI. Data are generally provided using electronic health system records or Uniform Bill (UB-04) administrative data claims or electronic file. Also used to track opioid related visits.

**Data Access**

Restricted use through the NCHS RDC: [https://www.cdc.gov/nchs/nhcs/nhcs\\_questionnaires.htm](https://www.cdc.gov/nchs/nhcs/nhcs_questionnaires.htm)

**Sample Description**

Annually, starting in 2013. Targeted sample of 581 hospitals per year.

**Main limitations with respect to health care cost and use analyses:** The focus is on patient care but does not contain information on costs. The hospital discharge data collected by the state of Alaska<sup>2</sup> should provide a more detailed alternative. Unfortunately, the discharge data does not have information on the actual payment but just the charge. It also is restricted to hospital visits and does not contain information about primary care/specialist cost or care.

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<sup>2</sup> <http://dhss.alaska.gov/dph/VitalStats/Pages/HFDR/default.aspx>

## Appendix 3: Select State Social Risk Data Collection Efforts and Screening Tools

Exhibit A3.1 below provides more detail on state sources and uses social determinants of health (SDOH) data. Since state agencies may not describe, or may change, the frequency with which they collect social risk data, we used a broad description of the frequency of data collection. Since agencies may use the data for more than one purpose, and we may not have full information on how states are currently using the data.

**Exhibit A3.1: Selected State Social Risk Factor Data Collection and Example Use**

Risk Factor	State	Data Collection and Example of Use		
		Tools for Data Collection	Frequency of Data Collection	Example Use
<b>Homelessness / Housing Stability</b>	Massachusetts	Claims and EHR data	Ranges from monthly to annually, based on state and tool.	Inform service eligibility; address social needs; research risk and health care use, reports for legislature, establish cost of care targets for MCOs and ACOs; adjust payment to providers.
	New York	Provider-fielded assessment tool (homelessness confirmed through self-report, letter from shelter, or hospital discharge summary)		
	Connecticut	Homeless Management Information System (HMIS)		
	New Jersey			
	Washington	SNAP and TANF databases		
	Michigan	Tablet-based checklist at home visits		
	Oregon	Survey administered to stakeholders		
	Tennessee	State-generated template completed by MCOs		
Ohio	Survey and assessments administered to beneficiaries			
<b>Incarceration</b>	New York	Provider-fielded assessment tool (confirmed through, release papers, documentation from parole/probation contacts, print-out from Webcrims, letter from halfway house)	Ranges from monthly to annually, depending on tool.	Adjust payment to providers; eligibility for home and community-based services and used in person centered care planning and linking to employment opportunities.
	Ohio	Survey and assessments administered to beneficiaries		



Risk Factor	State	Data Collection and Example of Use		
		Tools for Data Collection	Frequency of Data Collection	Example Use
<b>Serious and Persistent Mental Illness (SPMI)</b>	New York	Provider-fielded assessment tool (SPMI confirmed through hospital discharge summary, documented progress note, PSYCKES, MCO confirmation).	Ranges from monthly to annually, depending on tool.	Adjust payment to providers; identify individuals with mental health and SUD comorbidity; incorporate factor into P4P measures.
	Massachusetts	Claims data (6 HCC codes for serious mental illness)		
	Washington	SBIRT incorporated into mental health questionnaires		
	Louisiana	Encounter data		
	Oregon	Medicaid behavioral health risk factor surveillance system (MBRFSS) survey		
	Kansas	Member surveys incorporated into HEDIS Measures		
<b>Substance Use Disorder (SUD)</b>	New York	Provider-fielded assessment tool, confirmed through hospital records, parole/probation documentation, MCO or family confirmation	Ranges from monthly to annually, depending on tool.	Incorporate factor into P4P measures; enhance risk adjustment model; adjust payment to providers.
	Massachusetts	Claims data (7 HCC codes for serious mental illness)		
	Oregon	SBIRT incorporated into an EHR-based measure		
	Kansas	Self-reported data from The Kansas Client Placement Criteria Database		
<b>Poverty</b>	Vermont	Social Vulnerability Index (SVI) comprised of measures from American Community Survey	Neighborhood stress score updated annually.	The SVI is a planning tool used to evaluate the relative vulnerability of populations. The Neighborhood Stress Score was developed to enhance MassHealth's risk adjustment model
	New Hampshire			
	Massachusetts			
<b>Limited English Proficiency (LEP)</b>	Vermont	Social Vulnerability Index (SVI)	Depends on tool/program	Evaluate the relative vulnerability of populations in different parts of the state; cultural and linguistic service linkage; administrative purposes.
	New Jersey	Group Needs Assessment		
	Texas	Self-reported data added to the EHR system		
	New York	Provider-fielded assessment tool		

Risk Factor	State	Data Collection and Example of Use		
		Tools for Data Collection	Frequency of Data Collection	Example Use
Food Insecurity	Oregon	state-specific screening measures in EHR system	Ranges from "periodic basis" to every 90 days.	Informs P4P incentive program; informs service eligibility; identify social risks, assist in client goal development, community service/employment linkage, and care coordination.
	Michigan	Tablet-based check-list at home visit		
	Vermont	Uniform assessment tool administered by participating housing organizations		
	Ohio	Survey and resource assessment administered to beneficiaries		
	Pennsylvania	Screening tool for social programs		
	Illinois	Application for benefits eligibility		
Child Protection Involvement	Arizona	Child welfare data system & health plan data system linkage	In Arizona, the capitation rates are updated yearly;	Risk adjust rates to providers for services for children in the child welfare system or foster care; Incentive payments allow health centers to provide services and supports for children, foster parents, birth parents, and for receive training on working with this high-risk population. Arizona: 2018 capitation rate is \$245.79 for non-child welfare involved children and \$627.43 for children in the child welfare program. Michigan: Incentive payments are based on "risk categories" for children who use wraparound or home-based services or mental health services are higher
	Michigan	Child and Adolescent Functional Assessment Scale; encounter data	In Michigan, incentive payments are monthly case rate payments for eligible children, paid quarterly)	

Exhibit A3.2 below provides some examples of screening tools currently used mainly among state Medicaid populations, and measures assessed by each tool. For each tool, permission may be required from the authors for use or modification. Another additional database of tools can be found at Screening Times tool finder: <https://screeningtime.org/star-center/>

**Exhibit A3.2: Selected State Social Risk Factor Screening Tools**

Name of Tool	Social Risk Factor(s)/SDOH Examined	Example use
<a href="#">Accountable Health Communities Assessment Tool</a>	<ul style="list-style-type: none"> <li>• Housing instability</li> <li>• Food insecurity</li> <li>• Transportation needs</li> <li>• Utility needs</li> <li>• Interpersonal safety</li> </ul>	CMMI's Accountable Health Communities; permission
<a href="#">Medicaid Analytics Performance Portal (MAPP) Assessment Tool</a>	<ul style="list-style-type: none"> <li>• Homelessness</li> <li>• Incarceration release date</li> <li>• Inpatient state for mental illness discharge date</li> <li>• Substance abuse disorder use/functional impairment</li> </ul>	New York Health Homes
<a href="#">Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)</a>	<ul style="list-style-type: none"> <li>• Education, Employment, Housing Status</li> <li>• Migrant and/or Seasonal Farm Work</li> <li>• Insurance</li> <li>• Material Security</li> <li>• Transportation</li> <li>• Housing Stability</li> <li>• Social Integration and Support</li> <li>• Neighborhood Stress</li> <li>• Incarceration History (optional)</li> <li>• Safety (optional)</li> <li>• Refugee Status (optional)</li> <li>• Domestic Violence (optional)</li> </ul>	National Association of Community Health Centers
<a href="#">The Psychosocial Assessment Tool (PAT)</a>	<ul style="list-style-type: none"> <li>• Family Conflict and Substance Use</li> <li>• Family Resources and Structure</li> <li>• Social Support and Stress Reactions</li> <li>• Family Psychological Problems</li> <li>• Child Internalizing and Externalizing Problems</li> <li>• Child Cognitive and Social Problems</li> <li>• Child School Enrollment &amp; educational Placement</li> <li>• Family Medical Problems</li> </ul>	Children's Hospital of Philadelphia (CHOP)
<a href="#">Well Child Care, Evaluation, Community Resources, Advocacy, Referral and Education (WE CARE Project)</a>	<ul style="list-style-type: none"> <li>• Alcohol and substance abuse</li> <li>• Child care</li> <li>• Domestic violence</li> <li>• Homelessness, Education, Food insecurity, Unemployment</li> </ul>	Boston University Medical Center
<a href="#">HelpSteps</a>	<ul style="list-style-type: none"> <li>• Access to health care</li> <li>• Housing, food and income security</li> <li>• Domestic violence</li> </ul>	Boston Children's Hospital

Name of Tool	Social Risk Factor(s)/SDOH Examined	Example use
	<ul style="list-style-type: none"> <li>• Safety equipment use</li> <li>• Substance abuse</li> </ul>	
<a href="#">EveryONE Project</a>	<ul style="list-style-type: none"> <li>• Housing, Food, Employment, Education</li> <li>• Transportation</li> <li>• Utilities (water, gas, electricity, oil)</li> <li>• Child Care</li> <li>• Personal Safety</li> </ul>	American Academy of Family Physicians (AAFP)
<a href="#">Social Needs Screening Toolkit, HealthLeads USA</a>	<ul style="list-style-type: none"> <li>• Food Insecurity, Housing Instability, Employment, education</li> <li>• Utility Needs (electric, gas, oil, water)</li> <li>• Financial Resource Strain</li> <li>• Transportation Challenges</li> <li>• Exposure to Violence</li> <li>• Child Care</li> <li>• Health Behaviors, Behavioral/Mental Health</li> <li>• Social Isolation &amp; Support</li> </ul>	Complex Care Clinic at Virginia Commonwealth University Health System (VCU Health)
<a href="#">AccessHealth Spartanburg Social Determinants Screening Tool</a>	<ul style="list-style-type: none"> <li>• Education, Employment, Housing Instability, Food</li> <li>• Health Behaviors</li> <li>• Social Isolation</li> </ul>	AccessHealth Spartanburg
<a href="#">Self Sufficiency Outcomes Matrix, OneCare Vermont, CHCS version:</a>	<ul style="list-style-type: none"> <li>• Housing, Employment, Income</li> <li>• Legal and Community Involvement</li> <li>• Mental Health</li> <li>• Substance Abuse</li> <li>• Disability/Disabling Condition</li> <li>• Parental Supports</li> <li>• Transportation</li> </ul>	OneCare VT
<a href="#">Arizona Self-Sufficiency Matrix</a>	<ul style="list-style-type: none"> <li>• Housing, Employment, Food insecurity</li> <li>• Child Care</li> <li>• Children's and Adult Education</li> <li>• Health Care Coverage</li> <li>• Life Skills and Mobility</li> <li>• Parenting Skills, Family/Social Relations</li> <li>• Community and Legal involvement</li> <li>• Mental Health and Substance Abuse</li> <li>• Safety</li> <li>• Disabilities</li> </ul>	Abt Associates
<a href="#">Vulnerability Index- Service Prioritization Decision Assistance Tool (Adult file: VI-SPDAT)</a> <i>(there are also versions for individuals, families, and youth)</i>	<ul style="list-style-type: none"> <li>• Housing and Homelessness</li> <li>• Risks</li> <li>• Socialization &amp; Daily Functioning</li> </ul>	Hennepin County Office to End Homelessness, Minnesota Housing Finance Agency
<a href="#">SIREN interactive resource to compare SDOH screening tools</a>	<ul style="list-style-type: none"> <li>• This tool compares across domains but does not have unique domains to capture.</li> </ul>	

## Appendix 4: Detailed Table on Select APCDs

Exhibit 4.1 below summarizes the authority and use of APCD for 10 states: the seven states in our National Scan as well as three other states that were leaders in APCD implementation. As of May 2019, 20 states have legislation (Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Maine, Maryland, Massachusetts, Minnesota, New York, Oregon, Rhode Island, Tennessee, Vermont, Virginia, Washington, and West Virginia), according to the APCD Council.<sup>3</sup>

States can use an APCD to conduct detailed analyses of variation and trends in spending and utilization of health care over time across all payers. Such analyses inform and guide the evaluation of policy decisions that affect spending across all payers, regardless of the target population. All-payer data also inform benchmarking and growth monitoring, and indicate regional/geographic opportunities for improvement or interventions targeting community-specific needs.<sup>4</sup> Note that start-up costs for APCD and implementation costs are very difficult to find, and reflect the unique design, purpose, and end users of each database. Estimates listed in Exhibit 4.1 are those readily obtained from publically available information. More information on each state can be found at the hyperlinks in this document, and in resources including the organizations listed below and in “[The Basics of All-Payer Claims Databases: A Primer for States](#),” a policy paper with key considerations for states seeking to start APCDs, based on the experiences and lessons learned to date from other states.<sup>5</sup>

In addition to the states in Exhibit 4.1, two national organizations provide resources to support state efforts in implementation.

**1. APCD Council:** The Council is a national learning collaborative of government, private, non-profit, and academic organizations funded to promote the development and implementation of APCDs, with resources including a common data layout for data collection, APCD Development Manual, and other publications to support knowledge growth on developing APCD. It also conducts stakeholder meetings, legislation review, rule development, helps in vendor selection, analytics support, links states to each other to identify common solutions. It is coordinated through University of New Hampshire Institute for Health Policy and Practice and the National Association of Health Data Organizations (NAHDO).

**2. National Association of Health Data Organizations (NAHDO):** This was created by Washington Business Group on Health & George Washington University in 1986, to support state-level activities (collect, analyze, disseminate and use hospital discharge data sets). It aims to provide strategies and resources towards development of a nationwide, comprehensive, integrated health information system. It provides technical assistance and convenes forums to foster collaboration and the exchange of ideas and experiences. NAHDO is a national non-profit that partners with government agencies, educational institutions, and business leaders.

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<sup>3</sup> Available at <https://www.apcdouncil.org/apcd-legislation-state>

<sup>4</sup> Taylor E. and Bailit, M. (2019). Leveraging Multi-Payer Claims Databases for Value. State Health and Value Strategies. Washington, DC: Bailit Health [Webinar]. Retrieved from: <https://www.shvs.org/wp-content/uploads/2019/03/APCD-webinar-2019-3-27.pdf>.

<sup>5</sup> Porter, J., Love, D., Peters, A., Sachs, J., & Costello, A. (2015). *The Basics of All-Payer Claims Databases: A Primer for States*. Princeton, NJ: Robert Wood Johnson Foundation; January 2014.

## Exhibit A4.1: Characteristics of Selected State All-Payer Claims Data

State (voluntary or mandatory; year; state code)	Authority for APCD	How State Uses Data	Funding and costs (if available)	Administrator
<p><b>Arkansas, 2015, mandatory</b></p> <p>§ 20-7-301 to 306</p> <p>§ 20-8-401 through 403</p> <p>§ 20-7-301 et.seq.<sup>6</sup></p>	<p>The Arkansas Center for Health Improvement first launched as a nonprofit<sup>7</sup>. In 2015, the Division of Health within the Department of Health and Human Services (DHHS) tasked ACHI to collect and disseminate inpatient and outpatient surgery centers data for its price transparency.</p> <p>Data include billing, medical and personal information for inpatient and outpatient services, from Medicare, Medicaid, and fully-insured commercial plans with &gt;2000 beneficiaries.</p>	<p>The APCD is currently used to support state agency and health policy decision-makers.</p> <p>Researchers at ACHI are using the APCD to understand the impact of Medicaid expansion efforts in the state by comparing commercial claims to Medicaid claims.<sup>8</sup></p> <p>Future plans for the APCD include opening the database to academic researchers.</p>	<p>No data available.</p>	<p>Arkansas Center for Health Improvement with support and oversight from the Health Insurance Rate Review Division (HIRRD) at the Arkansas Insurance Department (AID).<sup>9</sup></p>
<p><b>Colorado, 2010, mandatory</b></p> <p>§ 10-16-104</p>	<p>The Colorado legislature mandated reporting of health care and quality data to enable transparency and require coverage provisions. The APCD is administered by the Executive Director of the Colorado Department of Health Care Policy and Financing (HCPF) and Center for Improving Value in Health Care (CIVHC), a non-profit organization focused on advancing the Triple Aim of better health, better care, and lower costs.<sup>10</sup></p> <p>Data include over 500 million claims from Medicaid, Medicare, Medicare Advantage, and the 21 largest commercial health</p>	<p>CIVHC makes APCD information available publicly and on a custom basis to consumers, researchers, state agencies, advocacy organizations, nonprofits, and others. Colorado APCD data has been analyzed to study price variation for common procedures among healthcare facilities.<sup>8</sup></p>	<p>The APCD was launched with funding from private grants and foundations. Data use fees and contracts with state agencies provide ongoing support.<sup>Error! Bookmark not defined.</sup></p> <p>The cost of administering the APCD in FY17 was \$4.4 million. The CO APCD earned</p>	<p>Colorado's Medicaid agency, the Department of Health Care Policy and Financing (HCPF), named the non-profit Center for Improving Value in Health Care (CIVHC), administrator of the CO APCD.</p>

<sup>6</sup> Delblanco, S. and Bazzaz, S. (2014). State Policies on Provider Market Power. National Academy of Social Insurance. Catalyst for Payment Reform. Retrieved from: <https://www.catalyze.org/wp-content/uploads/2017/04/2014-State-Policies-on-Provider-Market-Power.pdf>.

<sup>7</sup> Available at: <https://achi.net/our-people-partners/our-story/>

<sup>8</sup> Introduction to All Payer Claims Databases, prepared for Alaska APCD Business Case Assessment, sponsored by Alaska Health Care Commission. (2012). Newton, MA: Freedman HealthCare. Retrieved from: <http://dhss.alaska.gov/ahcc/Documents/AK-APCD-FeasibilityStudy-FinalBriefingPaper.pdf>.

<sup>9</sup> Available at: <https://www.arkansasapcd.net/Governance/>

<sup>10</sup> Available at: <https://www.civhc.org/about-civhc/who-we-are/>

State (voluntary or mandatory; year; state code)	Authority for APCD	How State Uses Data	Funding and costs (if available)	Administrator
	plans in the state, representing over 80% of insured Coloradans. <sup>11</sup>		\$2.5 million in revenue and received an additional \$1.9 million in grant funds. <sup>12</sup>	
<b>Maryland, 1998, mandatory</b>  <b>Md. HEALTH-GENERAL Code Ann. §§ 19-133</b> <b>Md. HEALTH-GENERAL Code Ann. § 19-202, 207</b>	The Maryland Health Care Commission was legislatively established as an independent regulatory agency focused on ensuring consumers are informed and have access to affordable and appropriate services. The legislation permitted the Commission to establish a Maryland Medical Care Data base that compiles statewide data on health services rendered by health care practitioners and facilities selected by the Commission. Legislation also requires the Commission publish an annual report that describes the variation in billed charges for procedures, health care costs, utilization, or resource use. <sup>6</sup>	The Medical Care Data Base (MCDB) supports policy and decision making and provides estimates of cost, efficiency and system utilization for State partners. <sup>13</sup> The database is intended to support system-wide comparisons and evaluations of waiver programs for decision-makers, rather than transparency for consumers. <sup>14</sup> Maryland APCD data has been used to compare the unit-costs, utilization, per-member per-month costs, out-of-pocket and insurance payments, geographic variations, and physician access across geographic regions. <sup>8</sup>	Cost of administration is approximately \$1 million dollars/year. About 90% of the cost is for research and system maintenance and about 10% is spent on overhead. <sup>14</sup>	The Maryland Health Care Commission is the administrator of the Medical Care Data Base.
<b>New Mexico</b>	NM introduced a bill to mandate an APCD for the State in 2015, but does not currently have an operational APCD.			
<b>North Carolina</b>	North Carolina has an established Task Force run through the NC Institute of Medicine (NCIOM) in collaboration with State government that is tasked with assessing the value of an APCD for NC. The NCIOM All-Payer Claims Database Task Force is funded by the Duke Endowment with the overarching goal of creating a set of recommendations for improving the sharing, dissemination, and use of health care claims data in North Carolina. <sup>15</sup>			
<b>Oregon, 2009, mandatory</b> <b>OR Rev Stat § 442.420</b>  <b>2014 OR H.B. 4109</b> <b>OR Rev Stat § 442.466</b>	The state legislature established the Oregon Health Authority to commission an independent study of costs in Oregon. The legislation requires entities to report health care data for multiple purposes, including studying costs of health care and quality	The Oregon Health Authority publishes quarterly reports that compare per-member per-month costs and utilization, by service category, for commercially insured, public employees, and public payers. <sup>8</sup> Additional	In 2008, the Oregon Health Fund Board suggested investing \$400,000 in state funds and \$300,000 in federal	The Oregon All Payer All Claims Database (APAC) was established by the Oregon State Legislature in 2009 and is

<sup>11</sup> Available at: <https://www.apcdouncil.org/state/colorado>

<sup>12</sup> 2017 CO APCD Annual Report: Charting the Health Care System in Colorado. (2017). Center for Improving Value in Health Care. Retrieved from: <http://www.civhc.org/wp-content/uploads/2018/02/2017-CO-APCD-Annual-Report-Final.pdf>.

<sup>13</sup> Available at: [http://mhcc.maryland.gov/mhcc/pages/apcd/apcd\\_mcdb/apcd\\_mcdb.aspx](http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx)

<sup>14</sup> Available at: <https://www.apcdouncil.org/state/maryland>

<sup>15</sup> Available at: <https://www.apcdouncil.org/state/north-carolina>



State (voluntary or mandatory; year; state code)	Authority for APCD	How State Uses Data	Funding and costs (if available)	Administrator
	control. <sup>6</sup> Data include all paid claims from commercial health insurance carriers, third party administrators, pharmacy benefit managers, Medicaid managed care organizations, Medicaid fee for service and Medicare parts C and D. <sup>16</sup>	uses include analyses of reimbursement and eligibility determination, quality improvement, and other IRB- approved research. <sup>17</sup>  OHA authorized the Office for Oregon Health Policy and Research (OOHPR) to maintain and conduct policy-oriented research on data reported by the entities.	funds to establish a database, bringing the total budget for the start up of the APCD to \$700,000. <sup>18</sup>	operated by the Oregon Health Authority (OHA).
<b>Washington, 2015, mandatory</b>  <b>RCW 70.41.250</b>	The Washington legislature established codes directing the Washington State Office of Financial Management (OFM) to establish the statewide all-payer health care claims database (WA-APCD) to support transparent public reporting of health care information. <sup>19</sup>  Data include medical service claims, including billed, allowed and paid charges, pharmacy and dental claims, member eligibility and enrollment and historical claims data from Medicaid, the Public Employees Benefits Board, all health insurance carriers in the state, all third-party administrators and the state Labor and Industries program.  The code also establishes requirements for disclosure of charged amounts of all health care services ordered for their patients to physicians and other health care providers (hospitals	Uses include: providing transparent public reporting of cost and quality data to assist consumers and providers to enable value-based health care choices; enabling providers, hospitals, and communities to improve by benchmarking their performance against that of others by focusing on best practices; enabling purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and promote competition based on quality and cost. <sup>19</sup>	CMS Cycle III and Cycle IV grants provided funding (\$3.40 million and \$1.12 million) to implement WA-APCD, develop a public website and produce products. <sup>19</sup>	The Oregon Health Sciences University (OHSU) to maintain the WA-APCD, with data support from Onpoint Health Data. <sup>20</sup>

<sup>16</sup> Available at: <https://www.apcdcouncil.org/state/oregon>

<sup>17</sup> Oregon All Payer All Claims Database (APAC): An Overview. (2018). Retrieved from: <https://www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/APAC-Overview.pdf>

<sup>18</sup> Collecting Health Data: All-Payer Claims Databases. (2010). NCSL Briefs for State Legislators: Health Cost Containment and Efficiencies. Retrieved from: [http://www.ncsl.org/portals/1/documents/health/ALL-PAYER\\_CLAIMS\\_DB-2010.pdf](http://www.ncsl.org/portals/1/documents/health/ALL-PAYER_CLAIMS_DB-2010.pdf)

<sup>19</sup> Available at: <https://www.apcdcouncil.org/state/washington-existing>

<sup>20</sup> Available at: <https://www.ofm.wa.gov/washington-data-research/health-care/all-payer-health-care-claims>



State (voluntary or mandatory; year; state code)	Authority for APCD	How State Uses Data	Funding and costs (if available)	Administrator
	and other facilities). Physician and other health care provider may then inform the patient of these charges and may specifically review them to increase transparency.			
<b>Washington - Voluntary</b>	The Puget Sound Health Alliance (now called the Washington Health Alliance) was a local voluntary effort that preceded statewide mandate. was established in 2004 in King County. The Alliance is a purchaser-led, multi-stakeholder collaborative with the goal of reducing cost and improving quality of the healthcare system. The development of the APCD was an initiative of the Alliance and covers a 5-county area in the greater Seattle metropolitan area (the Puget Sound region). <sup>21</sup>	The APCD contains information used in statewide datasets (i.e. Washington State Common Measure Set), data on resource use measurement and utilization and pricing data and is available to researchers, purchasers, providers consumers and other interested parties on a limited basis. <sup>21</sup>	\$1.5 million (initial), \$20 million since inception <sup>21</sup>	
<b>Other States</b>				
<b>Maine</b>	Operated by the Maine Health Data Organization (MHDO) since 2003, the database holds claims for all health care records for Maine residents. Claims are submitted monthly to the MHDO. MHDO also collects data from Maine hospitals, including general inpatient and outpatient information, quality and financial data. The statewide APCD has claims from commercial insurance carriers, third party administrators, pharmacy benefit managers, dental benefit administrators, MaineCare (Maine Medicaid), and CMS (Medicare).	The goal was to create and maintain a useful, objective, reliable, and comprehensive health information database that is used to improve the health of Maine citizens.		The Maine Health Data Organization serves as the administrator.
<b>Rhode Island</b>	Rhode Island formed its APCD, known as "HealthFacts RI", after legislation was passed	HealthFacts RI's mission is to provide actionable data to support the study and comparison of health	The penalties for a failure to comply in Rhode Island	The Director of the Department of Health is the lead

<sup>21</sup> Available at: <https://www.apcdouncil.org/state/washington-mandated>

State (voluntary or mandatory; year; state code)	Authority for APCD	How State Uses Data	Funding and costs (if available)	Administrator
	<p>requiring the Director of the Department of Health (the “Director”)</p> <p>Insurers, health care providers, health care facilities and governmental agencies must file reports, data, schedules, and statistics or other information, including health insurance claims and enrollment information; information relating to hospital finance; and any other information relating to health care costs, prices, quality, utilization, or resources required by the Director.<sup>22</sup></p>	<p>care data; to identify opportunities to improve health care quality and health outcomes and reduce health care costs; and to help Rhode Islanders make informed decisions about their health care.<sup>22</sup></p>	<p>include compliance orders issued by the state, fines up to \$300 and possible criminal penalties.<sup>22</sup></p>	<p>administrator for the APCD.</p>
<p><b>Massachusetts</b></p>	<p>The APCD enabling statute, Chapter 12C of Massachusetts General Laws, requires CHIA to draft regulations to ensure the uniform reporting of information from private and public health care payers.<sup>22</sup></p>	<p>A primary goal of the Massachusetts APCD is to promote administrative simplification that is beneficial to both insurers and state agencies. Insurers have been faced with complex, overlapping, and sometimes contradictory requests for data submissions from upwards of ten state agencies that use health care claims data in their research, regulatory activity, and operations in Massachusetts. The APCD will allow submission of data under a single submission specification and the Center for Health Information and Analysis (“CHIA”) is the sole agency responsible for maintaining data infrastructure and processes.<sup>22</sup></p>	<p>The penalty for non-compliance includes \$1,000 per week for each week that a Payer fails to provide the required health care data and information, up to an annual maximum of \$50,000.<sup>22</sup></p>	<p>Requires the collection of data from commercial payers, third party administrators, self-insured or self-administered plans, and public programs. The information is used by health care providers, health plans, researchers, and others to address a wide variety of issues, including price variation, population health and quality measurement.<sup>22</sup></p>

<sup>22</sup> Jagling, J. PLDW White Paper: The Benefits and Challenges of All-Payer Claims Databases. Providence, RI. Pannone, Lopes, Devereaux & O’Gara LLC.

## Appendix 5: Summary of Workforce Recommendations

Exhibit A5.1 summarizes recommendations for strengthening Alaska’s health care workforce, as identified from prior consultant reports.

**Exhibit A5.1: Summary of Past Recommendations on Workforce Capacity Building**

Source	Workforce Issue	Recommendations	Next Steps
<b>Office of Children's Services - Workforce Recruitment and Retention Strategies</b>	Recruitment and Retention	Determine baseline and engage in ongoing evaluation of recruitment and retention strategies	<ol style="list-style-type: none"> <li>1) Create systematic surveys and a database to track turnover, retention, worker characteristics, and strategies over time to help determine what is and is not working to improve worker retention.</li> <li>2) Exit interviews and surveys</li> <li>3) If the quality assurance unit is not able to develop and implement an evaluation framework, there may be opportunities to partner with UAA or another entity that can assist (grant, student, combination of QA unit and partner.)</li> </ol>
		Design recruitment and hiring process to identify key characteristics among recruits	<ol style="list-style-type: none"> <li>1) Develop a screening and hiring tools and protocol that helps identify characteristics shown to predict higher child welfare worker retention.</li> <li>2) Identify characteristics in current staff that have longevity and excellent work performance that can be incorporated into the development of new screening and hiring tools.</li> </ol>
		Provide benefits and supports to rural hires	<ol style="list-style-type: none"> <li>1) Collaborate with public, private, and tribal service agencies to develop or share workforce housing.</li> <li>2) Provide educational incentives as well as training and conference opportunities in urban areas for local rural hires.</li> </ol>
		Develop title IV-E and university partnerships	<ol style="list-style-type: none"> <li>1) Establish the best way to utilize Title IV-E funding based on previous experience and recommendations from research.</li> <li>2) Build on existing university partnerships and establish new higher education institution partners.</li> <li>3) Provide internships for students who aim to focus on children and families and who possess the attributes identified in research that correlate with success in child protection.</li> <li>4) Develop a standardized internship program that will properly recruit, engage, and train the intern.</li> </ol>

Source	Workforce Issue	Recommendations	Next Steps
		Maximize face-to-face time frontline workers have with children and families	<ol style="list-style-type: none"> <li>1) Conduct an audit to evaluate current workloads and allocation of tasks to determine changes needed to maintain manageable workloads and ensure frontline workers maximize the amount of time they spend with children and families.</li> <li>2) Include community partners in brainstorming ways their agencies could assist caseworkers.</li> <li>3) Identify tasks that can be streamlined or delegated, allowing more time for workers to conduct home visits and ensure families are receiving necessary resources.</li> <li>4) Ensure that frontline workers have the tools they need to be more efficient.</li> </ol>
		Flexible work schedules and family-friendly practices	<ol style="list-style-type: none"> <li>1) Explore alternative and creative schedules such as job sharing or having rotating schedules.</li> <li>2) Increase family friendly workplace policies.</li> <li>3) Rotate staff who are near burnout to another less intensive job assignment where they can cross train, and resume their original job if desired.</li> </ol>
		Recognize success	<ol style="list-style-type: none"> <li>1) Determine consistent ways to incorporate worker recognition into the culture of the agency.</li> </ol>
		Increase community collaboration efforts	<ol style="list-style-type: none"> <li>1) Enhance efforts to collaborate with other agencies, nonprofits, tribes, and community groups to increase support to frontline workers.</li> <li>2) Ensure that stakeholders, including the general public, are aware of the positive outcomes of OCS through public outreach campaigns.</li> </ol>
		Continue to strengthen supervisors and support a strong team approach	<ol style="list-style-type: none"> <li>1) Train and coach supervisors to foster a strong team approach and sense of peer support within their units.</li> </ol>
<b>Alaska Health Workforce Coalition 2017-2021 Action Agenda</b>	Systems building and capacity building	Engage and prepare Alaska's youth for health careers	<p><i>Streamline behavioral health and health care pipeline programs in Alaska</i></p> <ol style="list-style-type: none"> <li>1) Create a visual representation of the pipeline and associated programs to be utilized in advocacy, coordination, advising, and support.</li> <li>2) Promote CTE Exemplar Pathways to school districts and provide oversight and support to staff.</li> <li>3) Increase dual credit opportunities to students by engaging school boards, UA Health Program Alliances, and DEED.</li> <li>4) Increase opportunities for students to take part in intensive structured explorations programming (camps, ANSEP, Delia Keats, VHOP, etc.) across the state.</li> <li>5) Maintain pre-apprenticeships leading to healthcare occupations.</li> </ol>

Source	Workforce Issue	Recommendations	Next Steps	
		Training, competencies, and professional development	<p><i>Expand and enhance training and professional development opportunities for all healthcare professionals</i></p> <ol style="list-style-type: none"> <li>1) Provide inter-professional education and training opportunities in response to industry needs to Alaskan healthcare professionals.</li> <li>2) Increase and enhance healthcare provider’s toolbox by ensuring science-based conferences and trainings are offered statewide and when appropriate offer CEUs.</li> <li>3) Promote and expand Alaska Core Competencies trainings for DSPs.</li> <li>4) Expand and increase BHCE distance delivered trainings and video recordings for BH professionals and BH aides that enhance sensitivity to cultural needs and increase knowledge of EBP in BH interventions.</li> <li>5) Expand training of Certified Nursing Assistants with additional focus on dementia care.</li> <li>6) Expand and increase trainings that support Care Coordinators and Case Managers.</li> <li>7) Support/address Medicaid Expansion and Criminal Justice Reform identified training needs.</li> <li>8) Support the implementation of UAA’s Surgery Tech’s Associate Degree Program (fall 2017).</li> <li>9) Provide customized training to help support DBH staff and BH providers, under current Medicaid Redesign readiness processes and timelines to prepare for and transition to working effectively with service delivery under an Administrative Services Organization (ASO).</li> </ol>	
				<p><i>Train, strengthen and grow Alaska’s Peer Support Specialists occupational field.</i></p> <ol style="list-style-type: none"> <li>1) Expand training for Peer Support Specialists.</li> </ol>
				<p><i>As the healthcare industry requests, assist in the development of appropriate healthcare Federal Registered Apprenticeships.</i></p> <ol style="list-style-type: none"> <li>1) Monitor industry needs for Registered Apprenticeships in healthcare.</li> <li>2) As the healthcare industry identifies occupations of interest for Registered Apprenticeship assist with coordinating the planning and development.</li> </ol>
				<p><i>With the Department of Labor and Workforce Development develop and implement Registered Apprenticeships as requested by the healthcare industry.</i></p> <ol style="list-style-type: none"> <li>1) Support the implementation of the Community Health Care Worker, Clinical Medical Assistant, Medical Office Assistant and Certified Billers/Coders Registered Apprenticeships.</li> <li>2) Support the implementation of the Surgical Technologists and Central Sterile Processing Technicians Registered Apprenticeships.</li> <li>3) Support the implementation of the Behavioral Health Aide Registered Apprenticeship.</li> <li>4) Support the implementation of Registered Apprenticeship Program for Counselor Technician, Behavioral Health Technician, and Chemical Dependency Counselor.</li> </ol>

Source	Workforce Issue	Recommendations	Next Steps
			<p><i>Through a viable workforce presence, support and implement identified occupational priorities, findings, and recommendations related to Medicaid Expansion, Reform and Redesign.</i></p> <ol style="list-style-type: none"> <li>1) Assist the healthcare system with finding solutions to driving down the cost of healthcare.</li> <li>2) As requested, assist with the planning and implementation of the ASO – Administrative Service Organizations.</li> <li>3) Advocate for healthcare policy supportive of Alaska at the national, state and local level, as needed.</li> <li>4) As requested, assist the Department of Health and Social Services and the Trust with statewide redesign efforts.</li> <li>5) Federal and state grant-writing capacity.</li> </ol>
		Health Workforce Policies and Infrastructure	<p><i>Through a viable workforce presence, support and implement identified occupational priorities, findings, and recommendations related to Criminal Justice Reinvestment.</i></p> <ol style="list-style-type: none"> <li>1) Assist the Department of Corrections and local communities with reentry efforts.</li> </ol>
			<p><i>Work with the Licensing Boards on certifications, regulations, and licensing changes as statewide reforms and transformation efforts are implemented.</i></p> <ol style="list-style-type: none"> <li>1) The Substance Use Disorder/Addiction system is drafting regulatory changes to licensing and certification.</li> <li>2) Industry has requested increased trainings in science-based/evidence-based practices.</li> <li>3) Targeted licensing boards collect additional data at licensing and renewal.</li> </ol>
			<p><i>Ensure information about the Alaska Health Workforce Coalition is presented and available to interested parties.</i></p> <ol style="list-style-type: none"> <li>1) Develop an internal communication plan.</li> <li>2) Develop an external communication plan.</li> </ol>
			Health Workforce Recruitment and Retention
		<p><i>With the Alaska Primary Care Office, monitor SDMS effects and outcomes for Alaska's Health Professional Shortage Areas.</i></p> <ol style="list-style-type: none"> <li>1) Identify the findings of the AK Health Professional Shortage Areas.</li> </ol>	
		Health Workforce Data	<p><i>Determine the research and data project needed to assist the state with programming during FY18/19.</i></p> <ol style="list-style-type: none"> <li>1) The Trust, DOLWD R&amp;A and UAA COH will work together to develop a healthcare data project which uses existing data sets but new measurements that is based in "real time".</li> </ol>

Source	Workforce Issue	Recommendations	Next Steps
<b>Alaska Behavioral Health Systems Assessment Final Report</b>	Workforce Development	Close gaps in training and meet the increased demand for behavioral health services	<ol style="list-style-type: none"> <li>1) Provide continued support to workforce development efforts to ensure the behavioral health workforce has the training and supervision necessary at all levels to provide evidence-based, culturally competent therapies, bill Medicaid, use data to drive improvements to care, and pursue innovations such as team-based care and integration with primary care.</li> <li>2) Work at all levels of the system to fill gaps in the behavioral health workforce and tap the full potential of Behavioral Health Aides and other paraprofessionals to deliver needed care close to home.</li> </ol>
<b>Alaska Physician Supply Task Force Report</b>	Training, Recruiting, and Retaining Physicians for Alaska	Increase the in-state production of physicians by increasing the number and viability of medical school and residency positions in Alaska and for Alaskans.	<ol style="list-style-type: none"> <li>1) Increase the number of state-subsidized medical school positions (WWAMI) from 10 to 30 per year.</li> <li>2) Ensure financial viability of the AFMR through state support including Medicaid support.</li> <li>3) Increase the number of residency positions in Alaska, both in family medicine and appropriate additional specialties.</li> <li>4) Assist Alaskan students to attend medical school by: i) reactivating and funding the use of the WICHE with a service obligation attached, and ii) evaluating the possibility of seats for Alaskans in the planned osteopathic school at the Pacific Northwest University of the Health Science.</li> </ol>
		Increase the recruitment of physicians to Alaska by assessing needs and coordinating recruitment efforts.	<ol style="list-style-type: none"> <li>1) Create a Medical Provider Workforce Assessment Office to monitor physician supply and facilitate physician recruitment efforts.</li> <li>2) Research and test a physician relocation incentive payment program.</li> <li>3) Expand loan repayment assistance program and funding for physicians practicing in Alaska.</li> </ol>
		Expand and support programs that prepare Alaskans for medical careers.	<ol style="list-style-type: none"> <li>1) Expand and coordinate programs that prepare Alaskans for careers in medicine.</li> </ol>
		Increase retention of physicians by improving the practice environment in Alaska.	<ol style="list-style-type: none"> <li>1) Develop a physician practice environment index for Alaska.</li> <li>2) Develop tools that promote community-based approaches to physician recruitment and retention.</li> <li>3) Support federal tax credit legislation initiative for physicians that meet frontier practice requirements.</li> </ol>

## Appendix 6: Minnesota Accountable Health Model Continuum of Accountability Assessment Tool

The Minnesota Accountable Health Model developed the Continuum of Accountability Assessment Tool to help provider organizations assess their capabilities, relationships, and functions that would be needed to participate in and achieve the goals of the model. The Minnesota Department of Health (MDH) and Department of Human Services (DHS) used the tool to understand SIM-Minnesota participants (grantees, TA recipients, Accountable Communities for Health, and others) status and technical assistance needs. The results are used to identify areas for improvement and track changes over time. The tool includes 34 questions in seven categories:

1. Model Spread and Multi-Payer Participation (1 item)
2. Payment Transformation (1 item)
3. Delivery and Community Integration and Partnership(14 items)
4. Infrastructure to Support Shared Accountability Organizations (2 items)
5. Health Information Technology (8 items)
6. Health Information Exchange (6 items)
7. Data Analytics (2 items)

Below is the question from the Payment Transformation section of tool, provided as an example of the type of assessment Alaska could conduct to assess health care plan and provider readiness for health care reform goals. After each question, respondents can provide free text comments. The complete tool (updated in 2016) is available under [Resources on the Minnesota Accountable Health Model website](#).

**What types of alternatives to fee-for-service (FFS) payment arrangement(s) do you participate in?** *Select the level that best represents your organization, and within that level choose the appropriate response by checking the box.*

<p><b>Pre-Level</b></p> <p>We only receive payment for delivered services in the form of fee-for-service without any incentives.</p> <p><input type="checkbox"/>Beginning  <input type="checkbox"/>In progress  <input type="checkbox"/>Mostly done</p>	<p><b>Level A</b></p> <p>We have little or no readiness to manage global costs, but may be willing to assume fixed payment for some ancillary services. Examples include: Health care home or similar coordination fees, quality improvement/incentive payments.</p> <p><input type="checkbox"/>Beginning  <input type="checkbox"/>In progress  <input type="checkbox"/>Mostly done</p>	<p><b>Level B</b></p> <p>We are ready to manage global costs with upside risk. We participate in shared savings or similar arrangement with both cost and quality performance with some payers; may have some financial risk (e.g. episode-based payments).</p> <p><input type="checkbox"/>Beginning  <input type="checkbox"/>In progress  <input type="checkbox"/>Mostly done</p>	<p><b>Level C</b></p> <p>We are ready to manage global cost with upside and downside risk. We participate in shared savings and some arrangements moving toward risk sharing through Total Cost of Care or partial to full capitation for certain activities; may include savings reinvestments and/or payments to community partners not directly employed by the contracting organization.</p> <p><input type="checkbox"/>Beginning  <input type="checkbox"/>In progress  <input type="checkbox"/>Mostly done</p>	<p>We are ready to accept global capitation payments. Community partners are sharing in accountability for cost, quality and population health are included in the financial model in some form.</p> <p><input type="checkbox"/>Beginning  <input type="checkbox"/>In progress</p>
			<p><b>Level D</b></p>	



