

Alaska Pediatric Subspecialty Project



Presented to the All Alaska Pediatric Partnership
by the Tryck Consulting Group
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Executive Summary

The issue of pediatric subspecialty care in Alaska is long-standing. For many subspecialties, Alaska does not have sufficient demand to warrant or justify financially the presence of a full-time provider, let alone the multiple providers that would be needed for call coverage and redundancy in cases of unexpected unavailability. In 2019, a series of events spotlighted this issue and spurred the All Alaska Pediatric Partnership (A2P2) and partners to convene stakeholders at a workshop to consider potential remedies. That workshop established the foundational tenets and members of what would become the Alaska Pediatric Subspecialty Project, including both the larger working group and the core project team.

The project's goal was to identify and implement a sustainable system for pediatric subspecialty care in Alaska. To achieve this, the project team conducted extensive research into existing systems, legal structures, and financial models while meeting and collaborating with subject matter experts from the legal, business, healthcare, and health administration fields. Concurrently, the project team met semi-regularly with the working group to maintain interest and cement buy-in from relevant stakeholders.

While the project team explored the potential for developing an Alaska pediatric subspecialty clinically integrated network (CIN), ultimately a simpler option presented itself when two of Alaska's major health corporations – Providence Alaska Medical Center (PAMC) and Alaska Native Medical Center (consisting of Southcentral Foundation (SCF) and Alaska Native Tribal Health Consortium (ANTHC)) – were eventually galvanized to work with the project team to create a flexible and resilient partnership. This partnership was ultimately codified in an MOU that established the Alaska Pediatric Subspecialty Collaborative. With the MOU as a framework, the institutions began the process of stabilizing pediatric subspecialty care in Alaska.

1. Introduction

The issue of pediatric subspecialty care in Alaska is long-standing. For many subspecialties, Alaska does not have sufficient demand to warrant or justify financially the presence of a full-time provider, let alone the multiple that would be needed for call coverage and redundancy in cases of unexpected unavailability. Recruitment of such subspecialists can be difficult as well, as in some cases there are not many such providers in the country. Finally, families seeking care may have to travel hundreds of miles, even for care available within the State, while others must travel regularly outside the state.

This project was a response to a series of relatively minor incidents in early 2019. Those incidents revealed the continued vulnerability of current Alaskan pediatric subspecialty care systems to several factors, including: 1) the inability to recruit subspecialty physicians; 2) the retirement of or illness experienced by subspecialty physicians; and 3) changes in policy in one of the partner organizations that provide services. A series of conversations occurred to evaluate the level of interest in putting together a more comprehensive statewide solution for the delivery of high-quality subspecialty pediatric care to Alaska's children. Government representatives, healthcare organizations, private physicians, outside partners, non-profit sector personnel and other members of the public who may use or otherwise interact with subspecialty pediatric care providers participated in the discussions. From these conversations and from early research, initial project and process assumptions were developed. A day-long workshop was scheduled to assess interest further and to evolve the initial concepts of the project.

2. Launch

In November 2019, the All Alaska Pediatric Partnership along with Rasmuson Foundation brought together those interested in devising a realistic and sustainable answer to the long-standing challenge. Succinctly, the question was how to develop a sustainable, long-term pediatric subspecialty system in a context where it was highly likely that some level of subsidy would always be required.

Forty-seven people from across the state converged at the Alaska Native Heritage Center. During the workshop, stakeholders and others established the foundation of what would become the Alaska Pediatric Subspecialty Project (the Project). The meeting participants were surveyed, and the results laid the framework for the project mission and vision, values and goals, and an agreement was reached on the process concept.

Meeting participants self-selected to become part of a larger project working group, with members as diverse as independent providers, businesspeople, charities, hospitals, and administrative experts. Membership included representatives from around the state committed to the common goal of ensuring stable, sustainable, cooperative, and, where possible, in-state pediatric subspecialty care for all of Alaska's children. The final list of working group members follows.

Names of Working Group members

- Kevin Kollins: Pediatric Cardiologist
Seattle Children's Pediatric Cardiology of Alaska
- Erin McArthur: Pediatrician
Latouche Pediatrics
- Randall Zernzach: Medical Director: Child and Family
Developmental Services
Alaska Native Medical Center
- Scott Wellmann: Pediatric Cardiologist and founder
Alaska Children's Heart Center
- Laura Schulz: Pediatric Hematologist/Oncologist
Alaska Pediatric Oncology
- Kristi Davis: Chief Operating Officer
Alaska Pediatric Surgery & Alaska Pediatric Oncology
- Tanya Dumas: Program Officer, Rasmuson Foundation;
Board Member, All Alaska Pediatric Partnership
- Matthew Hirschfeld: Medical Director: Maternal Child
Health Services; Alaska Native Medical Center; Board
Member, All Alaska Pediatric Partnership
- Tamar Ben-Yosef: Executive Director
All Alaska Pediatric Partnership
- Kari Burrell: Community Planning & Partnerships
Director, Foundation Health Partners (Fairbanks, AK)
- Bruce Hess: Pediatrician
Ptarmigan Pediatrics (Wasilla, AK)
- Cathy Heckenlively: Director, The Children's Hospital &
Women's Services, Providence Alaska Medical Center;
Board President, All Alaska Pediatric Partnership
- Wes Gifford: Medical Director, Pediatric Hospitalist
Program, Alaska Regional Hospital
- Laura Brunner: Pediatrician, Tanana Valley Clinic
(Fairbanks, AK); Board Member, All Alaska Pediatric
Partnership

From that group, a smaller (ad hoc) core team was established to drive the project forward. Core team members worked on specific and detailed tasks. The membership changed as appropriate, depending on the specific skills needed for the varying phases of development.

3. Project process and tools

The core team identified a few early assumptions that would guide the project's process. These included:

1. It was highly likely that the system would never be financially self-sustaining. For this reason, the process needed to include substantial input and buy-in from a wide range of Alaskans. Furthermore, the system would need to explore cost-saving options as much as possible while maintaining high-quality care.
2. In the research and development process, it would be vital to cast a wide net. Not all lines of inquiry would produce actionable results.
3. The system needed to be flexible and resilient.
4. The development process would evolve to reflect changes in direction and partner involvement.
5. The final system might not look at all like the one envisioned at the beginning of the process.

Furthermore, a general engagement process was established to ensure regular flows of input and feedback (Figure 1), both with institutional partners and with healthcare community members.

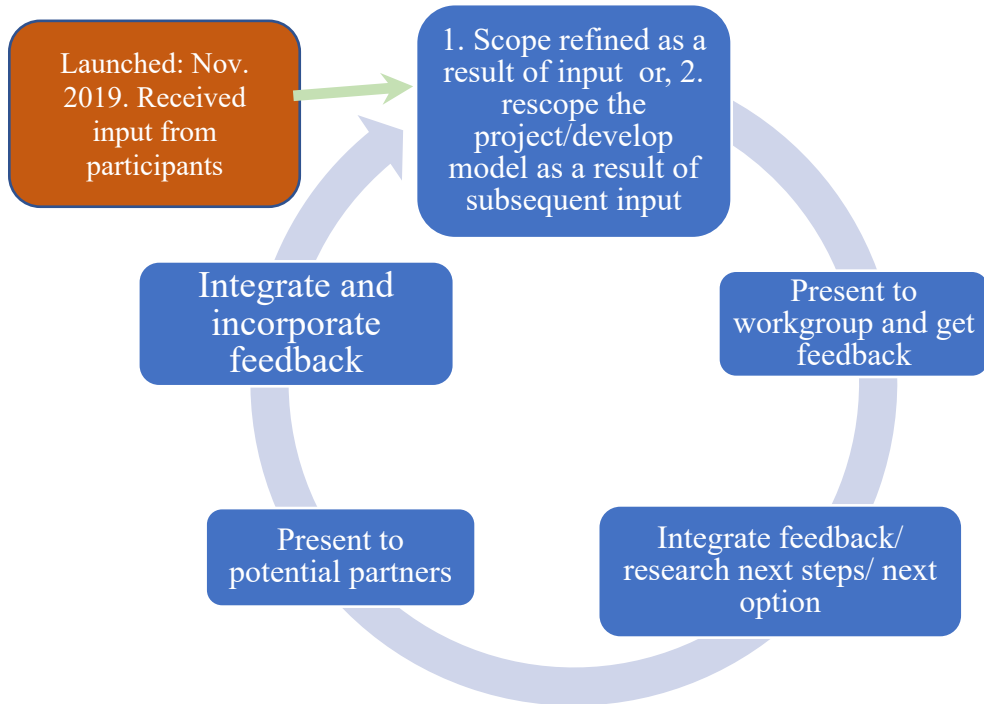


Figure 1

This process ensured regular communication, and was vital to achieving buy-in by:

- maintaining a level of interest and support for the project aims, values, and development
- informing the working group and community of the status and project development
- listening, requesting, and gathering input to ensure the project continues to develop in keeping with the working group (and others’) goals and expectations
- incorporating the information received from the community as appropriate

4. Initial phases

The early phases of the project focused concurrently on three principal areas: establishing lines of communication and gathering support, identifying gaps, and preliminary research. Early lines of communication involved regular meetings of the core team as well as semi-regular meetings of the larger working group. From the outset, it was clear that maximizing and maintaining disciplined engagement would be critical, since so many stakeholders around the state could influence and be influenced by the ultimate product.

Any new system would require partnering. To be truly sustainable, this partnering would require broad buy-in. The more major entities participate, the more realistic the system becomes, as practitioners employed by such entities could be involved in improving the care delivery system in Alaska. This type of involvement also increases the likelihood of gaining support in other quarters. The challenges of providing care in the remote geographic locations in Alaska are not insurmountable if partnering and combined efforts are made. To that end, the engagement process remained a foundational element in the project.

The core team also used these communication lines to update the working group on the second principal effort: building and sustaining initial support. Early on, this centered on codifying the foundations of the Project as had been determined by the workshop participants.

Part of the workshop's goals had been to identify what the stakeholders envisioned as key elements of any new system. From these elements the core project team developed the key tenets of the Project: sustainability (lower costs), community (care should be provided as close to home as possible), cooperation (engaging with all relevant stakeholders), and inclusivity (consideration of Alaska's diverse contexts) (Figure 2).

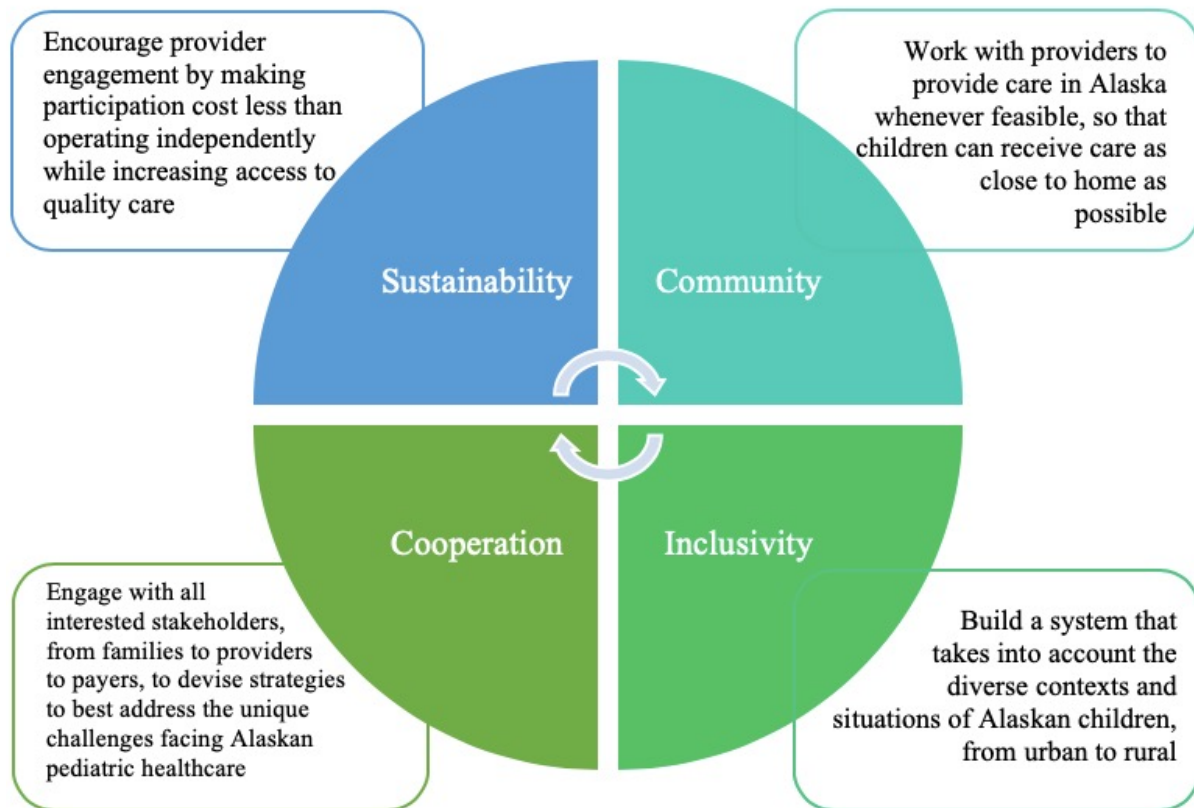


Figure 2

The team also used the stakeholders' input to synthesize the project's mission and vision statements, which were also approved by the working group.

- Mission: uniting providers, families, and organizations to build a comprehensive, sustainable model for Alaskan pediatric subspecialty care.
- Vision: to provide all Alaskan children with the pediatric subspecialty care they need.

Furthermore, the core team drafted a resolution on the aims and direction of the project to further solidify stakeholder buy in and ensure that the message across stakeholders and project team members was consistent. This resolution, reproduced below, was reviewed and accepted by the majority of the working group members.

WORKING GROUP RESOLUTION – May 28, 2020

We, the members of the Pediatric Subspecialty Workgroup, agree with the direction of the proposed Pediatric Subspecialty System for Alaska with the goal of a structure that meets the mission and vision as outlined in this presentation. We assert that this project continues to be a priority, even and especially given the current situation with COVID-19.

We believe that if this plan progresses on this path, it will provide a more sustainable system that addresses the pediatric subspecialty needs of patients and families in Alaska. It will also provide high quality pediatric care as close to the patient's home as possible.

We encourage all organizations in Alaska with an interest in Pediatric Subspecialty services, including the State of Alaska, funders, and hospital/clinic systems, to collaboratively participate in the further development of this program, with the goal of providing a unified system of pediatric subspecialty services for all of Alaska.

The second major effort of the first phase centered on establishing the status of pediatric subspecialties and relevant support service in Alaska. This environmental scan largely involved interviews and meetings to gain insight into what institutions and providers viewed as the most critical pediatric subspecialty needs. These early efforts resulted in a Dashboard (Figure 3) that depicted the complete set of relevant pediatric subspecialties, along with their status and service location. In this manner the subspecialties were divided into five categories: ‘stabilize first’ (those most vulnerable to failure); ‘stable and working’ (not in need of support); ‘in-state at risk’ (potentially vulnerable to loss of in-state services); ‘out-of-state at risk’ (potentially vulnerable to loss of established out-of-state service lines); and ‘complementary services at risk’ (potentially vulnerable services that provide support to subspecialty care).

Stabilize first	Stable and working	Instate: at-risk	Out of state: at- risk	Complementary services: at-risk
Peds surgery-pp*(co locate) GI—PP plus prov**(co locate) Heme/Onc-pp**(co locate)	ENT-PP ANMC Ortho- PP ANMC Cranial facial-PP clef clinic/ANMC Dental PP ANMC Neurosurgery ANMC and PP Cardiology pp plus SCH*(co locate) NICU-ANMC plus contracted phys PROV plus prov space and support Regional/FBKS PICU- ANMC plus contracted phys PROV plus prov space and support Hospitalist- ANMC plus contracted phys Prov plus Prov space and support Regional/FBKS	Neurology-Prov/ANMC/ Bethel/Sea Children’s*(co locate) Nephrology-PP contracted with Prov*(co locate) Endocrine-Prov plus ANMC*(co locate) Pulmonology-Prov plus ANMC/Sez Children’s/Bethel-Sea Children’s*(co locate) Neuro-developmental-ANMC/Prov/State of Alaska /Ptarmigan-Valley—maybe co locate Psychiatry-Prov (inpatient)/Northstar (Inpatient Service); ANMC outpatient; PP plus telemedicine- maybe co-locate Urology-PP* Palliative Care-ANMC/ Prov* (co locate)	Genetics-ANMC*(co-locate) Metabolic genetics-State of Alaska*(co locate) Rheumatology Sea Children’s Adolescent Medicine Sea Children’s*(co locate) Rehab Medicine Sea Children’s*(co locate)	Pediatric therapies-PROV/ANMC/PP (PT, OT, SLP, ABA) *(co locate) Child life-ANMC and Prov*(co locate)
Outside of Alaska Specialties	Cardiac Surgery; Major Neurosurgery; specialty inpatient psych; ECMO; Very high needs, medically complex Children requiring inpatient services;			

By mapping out and categorizing the complete world of subspecialties and services relevant to the project, the core team was able to narrow the focus to where it was most needed.

After establishing in broad terms, the condition of subspecialty care in Alaska, the core team took the analysis down a level to gain a regional and community focus. This required extensive research as well as many meetings with providers and institutions around the state. For example, throughout 2020 and 2021 the team met with, among others,

- Providence Alaska Medical Center,
- Alaska Regional Hospital,
- Southcentral Foundation,
- The Children’s Hospital at Providence
- Fairbanks Memorial Hospital (and other local health sector stakeholders from military bases and the Native health system)
- Mat-Su Valley interested parties
- All Alaska Pediatric Partnership Board of Directors

These meetings served both to raise further awareness of the project and to better identify the range of unique contexts of different pediatric subspecialties within Alaskan communities—e.g., the differences in care gaps and instabilities in Anchorage vs. Fairbanks. As one of the project’s guiding principles was ‘community’—providing care as close to home as possible—this was crucial information. In addition to assessing need, these meetings—with major Alaskan healthcare institutions as well as with groups of providers and subspecialists—helped build a collaborative and participatory model of engagement and community.

Finally, the team began preliminary research into potential models to gain a better understanding of where further research should focus. This included researching how care was delivered in other atypical or remote geographic contexts, from other rural states to Samoa.

5. Modes of care delivery

The outreach and identification of gaps would be an iterative and ongoing process for much of the project's duration. While that process was underway, the core team turned to the issue of system design. Core questions included:

1. Who could deliver care?
2. How could care be delivered?
3. How could it be done sustainably?

These questions drove research into what system or structure would be most able to deliver on the highest priority needs while also aligning with the guiding principles identified and elaborated in the initial project phases.

The core team began exploring alternatives through legal and regulatory research and through meetings with experts and outside educational institutions. From this long and iterative process, the core team distilled a set of alternative and innovative modes of care delivery. Incorporated into a system, these modes would encompass a wide range of care delivery options and offer maximum flexibility.

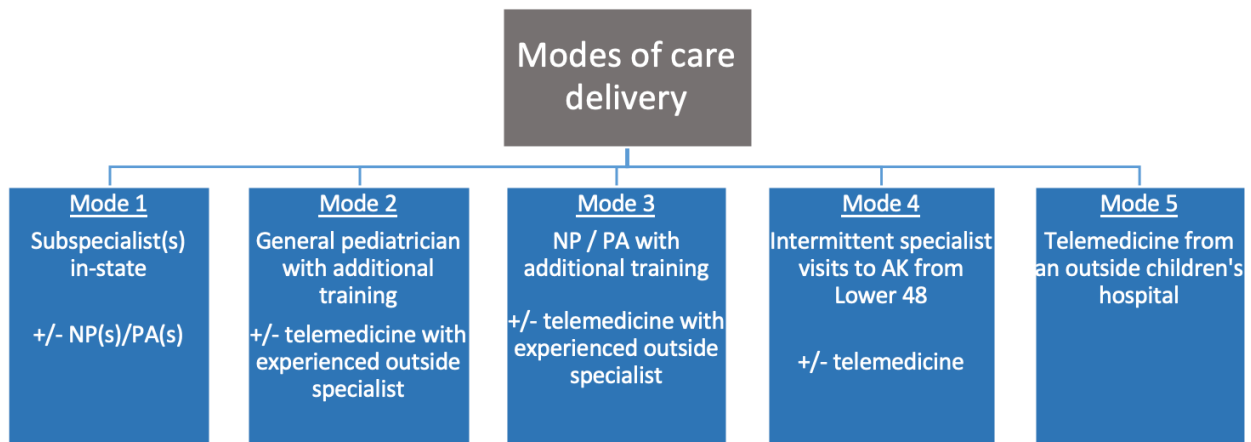


Figure 3

The modes of care delivery provided a partial answer to all three questions. They most explicitly addressed the ‘who’ element (listing out the range of possible providers, from subspecialists to specially trained advanced practice providers) and the ‘how’ element (with various care delivery formats, from telemedicine to outreach clinics). In addition, they began to address the question of sustainability. If high-quality care could be delivered by alternative providers or via methods other than in-person visits, this could help relieve some of the logistical, practical, and financial burden of having a pediatric subspecialist physician to address every potential need.

Of course, not all subspecialty care could be delivered via each of the modes; for example, some subspecialties may be largely operational through telemedicine, while others require the in-person presence of a subspecialist provider. To that end, research into training general pediatricians and other non-subspecialty pediatric providers for specific subspecialty care delivery was explored with interested medical schools. Also explored was the possibility that pediatric subspecialty fellows could make up part of the complement of providers of subspecialty care in Alaska. These types of alternatives could improve the system’s long-term sustainability and help deliver on the project’s goal of keeping care close to home for children and families.

With the spectrum of potential modes and providers identified, the core team combined the dashboard and the modes of care delivery to fully map the range of options for providing pediatric subspecialty care in Alaska. These were then grouped by general type and visualized in Figure 4.

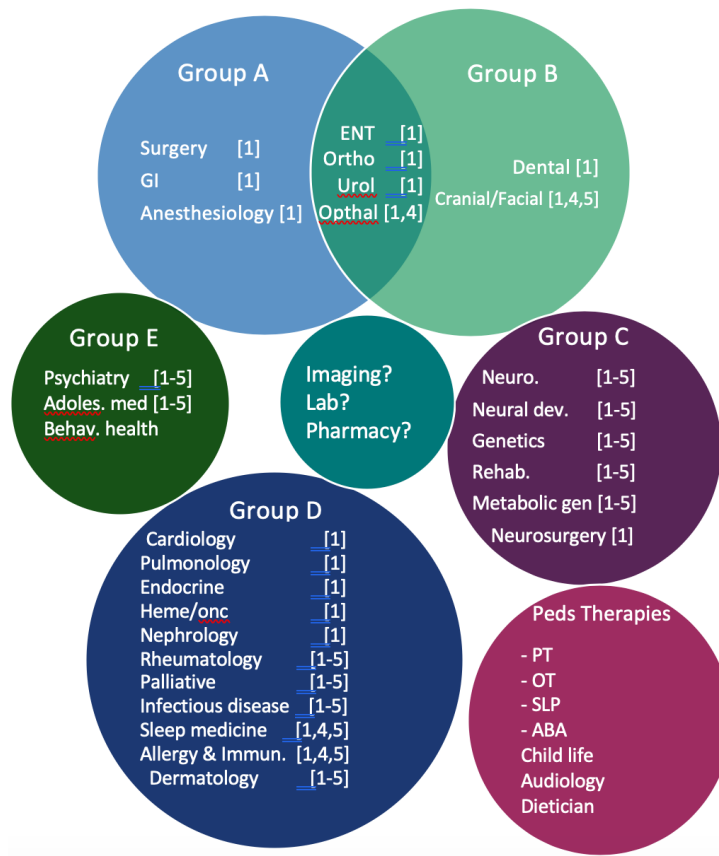


Figure 4

Throughout these assessment and mapping activities, the team continued in their community outreach efforts. Soon this outreach included connecting with outside institutions which had been or continued to be involved in pediatric care in Alaska in some capacity, including Seattle Children’s Hospital and the Primary Childrens’ Hospital in Salt Lake City. These connections served several purposes. First, these were long-standing entities with significant institutional knowledge. Second, since four of the modes of care delivery required engagement with outside institutions for training or care delivery, the core team knew that such institutions may end up playing a critical role in the final system.

Along with these activities, it was important to determine the bounds of the new system – what types of care would fall under its purview and what would not. The following graphic (Figure 5) illustrates the project’s conclusions on that subject.

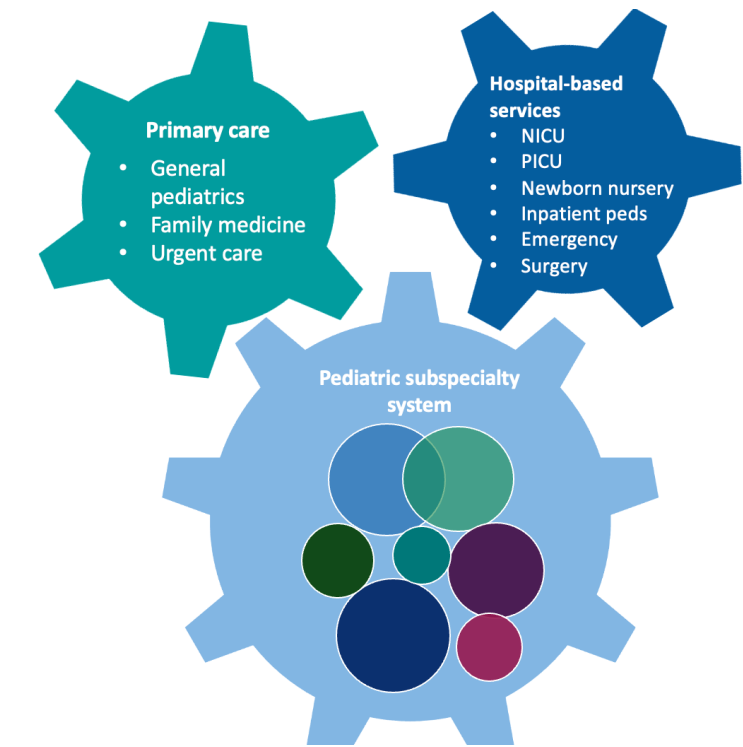


Figure 5

6. System structure

Having laid the project's foundation and parameters, the focus shifted to the most complex element of the project: that of system structure and design. The project's end goal had always been the implementation of an active and sustainable system, not a plan or outline for a system. The team did not intend to duplicate the work of any other consultants, but rather use the earlier efforts as a base.

The core team began with some of the basic assumptions that had formed the foundation of the project. The system needed to be sustainable to ensure its long-term viability. The structure needed to have the flexibility to incorporate the involvement of a wide range of actors, from independent providers and practices to hospitals, health systems, and employed providers, while ideally allowing for the potential to employ some personnel itself. It needed to have a governance structure that would encourage collaboration and incorporate voices and representatives of the many interested stakeholders, an aspect that could in turn encourage participation and financial support.

Finally, it needed to be resilient and capable of withstanding unexpected fluctuations in provider availability, such that Alaska’s children were not relying on the availability of a single provider to receive necessary care. The modes of care delivery had taken this into account by incorporating elements such as telemedicine and additional training for non-subspecialists, acknowledging the need for a level of redundancy in care options. The challenge would be finding a single, integrated system that allowed for the incorporation of all these elements. The core team began researching potential designs, both from the legal aspect and through existing systems that may serve as a model.

Since much of the current pediatric subspecialty care infrastructure is decentralized, one long-term option discussed during the November 2019 launch was to co-locate pediatric subspecialties in Alaska. Co-location could serve both to improve the patient and family experience (e.g., in only having one location to visit for multiple provider types) and to reduce overhead costs through savings in rent. Furthermore, co-location could allow cost savings through economies of scale in purchasing and some shared administrative services, such as scheduling, front desk needs, and other services outline below (Figure 6).

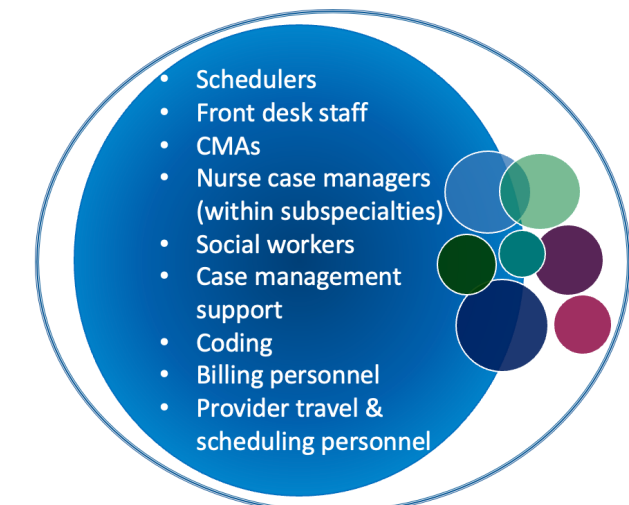


Figure 6

In addition to cost-savings considerations, the team began to explore methods of maximizing reimbursement. Considering that the subspecialists and services in question would likely be a mix of independent and employed providers, the team began researching what legal and governance structure would allow for this.

After considerable time researching, the team connected with various outside systems. One promising system was The Children’s Village in Yakima, Washington. This model incorporated streamlined, co-located care and services for children with special health care needs, providing some such services on a permanent basis while hosting intermittent clinic visits from external institutions to provide a broader range of services than would be justifiable on a permanent local basis. While these practices were in line with some of the Alaskan project’s identified modes of care delivery, the context of care availability and financial support was different enough from Alaska’s situation that the model did not prove workable for the project.

The team began researching Clinically Integrated Networks (CINs). Though based in anti-trust law—not health care law—the term CIN has become the standard for referring to networks of providers and hospitals/health systems joining together to share data, employ standardized measurement tools, and improve care quality in a specified population. Through these continual activities, the participants can achieve a level of integration (which can be clinical, financial, or both) such that the Federal Trade Commission will allow the network to conduct contract negotiations on behalf of all participants, whether they be hospitals or small independent practices. In demonstrating value through improved care quality, integration to reduce redundancies, and through incorporating continual measurements that produce verifiable data on quality of care, these networks are often able to reduce overall costs and achieve higher rates from payers—rates that participants may not be able to negotiate individually—and negotiate value-based care contracts. This model held promise in that it could potentially provide a level of stability through reduced costs, potential increased revenue, and through its contracting ability.

The project team examined the potential development of a CIN from multiple angles, including through financial modelling and through regularly checking research results and potential partnerships against a series of guiding questions. Examples of such questions include:

- What are the various legal structures of partners?
 - Are the organizations compatible?
- How could collaboration potentially increase the effectiveness of each partner?
- What would comprise the general terms of transactions?

- Would care be delivered as close to home as possible?
- Does the system engage with all interested stakeholders?
- Would the integration cost less as a whole than the current system, while increasing access to quality care?
- Would the system be inclusive of Alaska's diverse contexts?

As this model progressed, the Project met with two major health institutions in Alaska to update them on the Project's direction. Among these meetings was one with the consulting team that was developing a CIN for Providence Health Systems. In addition, the team researched CIN models that were both hospital-based and nonhospital-based. Included in that process were a series of meetings with members of a small existing CIN in Alaska and with Seattle Children's Hospital, which had established their own CIN.

The Project work continued to focus on the development of a CIN with the support of the Working Group. The core team continued to meet with hospitals and health systems to build further support and potential buy-in while also consulting with an attorney who had experience in CIN development and a financial consultant experienced in systems development and public-private partnerships. Furthermore, the team explored the option of CIN accreditation from the Utilization Review Accreditation Commission (URAC), a nonprofit that validates certain healthcare systems' and entities' compliance with the highest industry legal and quality standards. In the case of CINs, this included measurements for continued quality improvement, operational efficiencies, and antitrust compliance. The core team knew that a CIN would not be easy or quick to establish. There are strict requirements governing many basic elements of CINs, especially governance, participation, and operations. These requirements aim to restrict the possibility of reducing competitiveness in the market and risking antitrust action. URAC accreditation could help ensure compliance with these requirements.

Regarding governance, the team developed a number of potential ownership and participation models for the CIN, including the following example. Such models were presented to the major Alaskan institutions.

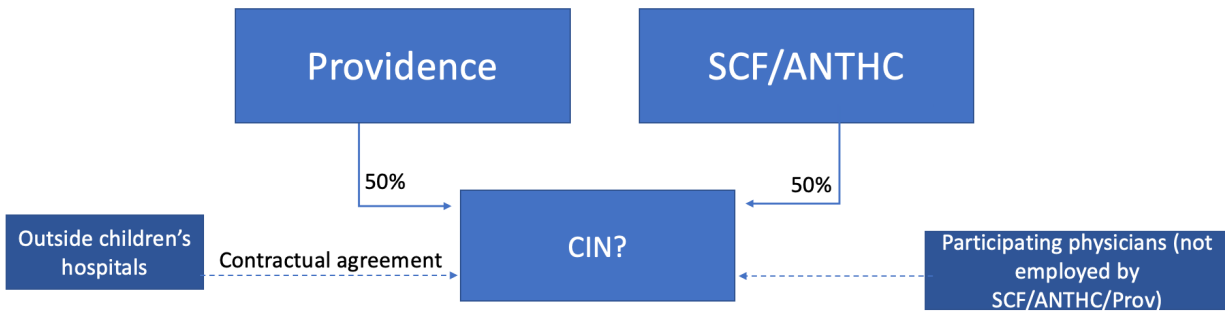


Figure 7

Another related legal concern, especially among providers and hospitals/health systems, was ensuring compliance with the physician self-referral law (also known as Stark Law). The project built this element into its process, thoroughly researching Stark Law, its exceptions, and identifying potential compliance issues with the understanding that these issues could inform the final legal structure and requirements for participants in the new system. However, in late 2020, CMS released a Final Rule incorporating new exceptions around value-based entities (including CINs) that could provide some relief to the stringencies that the former Stark regulations might have placed on the system.

However, the project team ultimately began to question whether a CIN was the most efficient or effective structure for achieving project goals. The benefits, while potentially valid for existing practices, did not necessarily fill the funding gap or resolve the various issues. There are typically significant start-up costs—often dependent on owner investment and participant dues—as well as ongoing operational costs. Once established and fully running, participant dues and revenue from increased rates often covers the operational costs of CINs; however, it can take a few years before the entity is ready for joint contract negotiations. In addition, per the results of financial modelling exercises, the Alaskan pediatric subspecialty CIN might not ever have sufficient membership for the benefits to outweigh the costs. Finally, as any CIN would aim to support subspecialties that are not self-sustaining and to contract with outside organizations for care not available in Alaska, the CIN would likely require some level of ongoing subsidy from owners.

Through the first part of 2021, these CIN options were reviewed and meetings with the Providence team developing CINs occurred. From those meetings, the continued consultation with legal experts, and the factors outlined above, it became clear that simpler options could be developed

that could operate as the foundation for the Pediatric Subspecialty delivery system. If a CIN would essentially depend on the support of the two major Alaskan health systems—Providence Alaska Medical Center and the Tribal health system—for development and survival, it would be legally and administratively simpler to build a solid partnership between the two. To this end, the project team began conducting joint meetings with leadership from these two systems.

7. Alignment of the Alaska Native Tribal Health Consortium, Southcentral Foundation, and Providence Alaska Medical Center

Over the course of the project, it had become clear that buy-in from the three major healthcare corporations that provide pediatric care in Alaska was critical. In whatever way they could come together, any Alaska pediatric subspecialty model would be more sustainable if built on an agreement forged between the two systems.

In the series of leadership meetings, the team worked to establish provisions to be included in an MOU between the systems to establish an Alaska Pediatric Subspecialty Collaborative. In accordance with the initial goals and values established at the beginning of the project, the purpose of the MOU is to provide a framework to discuss, collaborate and develop ways to promote shared interests in pediatric subspecialty care in Alaska. Specifically, the parties sought to improve the quality of and access to pediatric subspecialty services as close to home as possible, to improve the experience of patients and their families, improve the health of the population, reduce costs through collaboration, and improve health care team satisfaction.

In its final form, the MOU defines its goals as follows.

1. Patient and Family Experience
 - a. Expand patient access, service, and quality in Alaska, keeping patients and families close-to-home when possible and appropriate to do so.
 - b. Explore coordinated care/case management to facilitate care and reduce the burden on families.
2. Health of the Population

- a. As permitted by law and regulations, share appropriate clinical and operational information, data, and expertise to deliver the best outcomes, including through improved health information sharing.
3. Reducing costs
 - a. Reduce duplicate hiring and care delivery for pediatric subspecialists.
 - b. Increase the efficiency of information-sharing to reduce duplication of pediatric subspecialty services.
 - c. Seek opportunities to train general pediatricians and/or advanced practice providers to provide certain types of pediatric subspecialty care.
 - d. Explore opportunities for increased utilization of telemedicine for pediatric subspecialty care, especially in rural communities.
 - e. Collaborate with one or more children's hospitals outside of Alaska to provide pediatric subspecialty care in Alaska when a full-time pediatric subspecialty provider is not needed.
 4. Pediatric Subspecialty Health Care Team Satisfaction
 - a. Improve the stability of the workforce of health care professionals providing pediatric subspecialty care by enhancing recruitment and retention of pediatric health care team members in Alaska and by partnering with other children's hospitals to provide back up to pediatric subspecialty health care team members.
 - b. Enhance and develop professional collaboration among pediatric health care team members providing pediatric subspecialty care.

The MOU also lists guiding principles to align systemic efforts. These principles were:

- Expanded Access to Pediatric Subspecialty Care for Children in Alaska
- Mutual Respect
- Information Sharing
- Efficiency
- Compliance with Applicable Policies, Laws and Regulations
- Assistance for Special Needs Children
- Access to Research
- Growth and Collaboration.

- Innovative Care Models
- Pursuing Philanthropy

The MOU further outlines a process for developing specific contracts for particular services or subspecialties. By creating a process wherein these contracts are developed individually, the system can remain intact if a specific element or subspecialty meets with difficulty. This aligned with the project's original goals of flexibility and resilience.

In addition, individual contracts allow the Alaska Subspecialty Pediatric Collaborative development to occur over time and to be tailored specifically in how the care will be delivered, utilizing the modes of care delivery models developed during the project and described above.

The MOU was signed by SouthCentral Foundation, Providence Health and Services Alaska and Alaska Native Tribal Health Consortium in the spring of 2022. The foundation document creating the Alaska Pediatric Subspecialty Care Collaborative was completed.

Since that time, work has been done to develop the first agreement in the new system. Once that agreement has been signed, the process for development will be codified and the foundation for the Collaborative will be established. On that foundation other contracts will be developed in keeping with the goals established during the initial meeting, elaborated throughout the project's life, and codified in the MOU.

8. Conclusion

With the MOU signed, the project has moved out of the development phase and into the implementation phase, which holds new challenges as hospitals are still reeling from the impacts of the Covid-19 pandemic. Despite these challenges, work has begun to develop the first agreements in the new system to establish stable services for several pediatric subspecialties: namely endocrinology, gastroenterology, infectious diseases, and nephrology. Both SCF and PAMC have been working on agreement negotiations and provider recruitment. As these negotiations are still in process, it is too early to determine how the individual agreements for these pediatric subspecialties will be set up and where.

Once several of the individual subspecialty contracts are signed, the foundation for the Collaborative will be established. Other contracts will be developed in keeping with the goals that were first established during the 2019 workshop, then were elaborated throughout the project's life, and finally codified in the MOU. Now, like any system, The Alaska Pediatric Subspecialty Collaborative will require ongoing commitment and buy-in to continue its evolution into a sustainable and enduring system.

9. Attachments

November 2019 Launch Meeting Participants

Name	Organization	Email
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